

**An analysis of the involvement of community
nurses in clinical governance**

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Introduction

To-day we have naming of parts. Yesterday,
We had daily cleaning. And to-morrow morning,
We shall have what to do after firing. But to-day,
We shall have naming of parts

Henry Reed, (1942).

This research arose from concerns related to the increasing requirement that members of the nursing profession identify, name and measure the parts of nursing and the care provided for clients groups. The study is set within the context of the government led reforms of NHS management during the period 1983-2000. Specifically, this research developed from experiences gained from working with nurses as they were involved in setting standards, conducting clinical audit and using evidence based practice (EBP). I questioned what the nurses were actually doing, how they were doing this, what was being gained or lost for the nurses involved, for the patient and, ultimately, the profession. Specifically, this research seeks to explore the involvement of nurses in the clinical governance agenda and to address how they are conceptualising this in practice.

The development of a quality agenda in health care has, over a period of two decades, increased to represent the interests and concerns of the health professions, managers and client groups. Consequently this period saw a proliferation of quality philosophies, systems and methods, although there was little apparent integration between them. Throughout this period, the nursing profession played an active role with nurses involved in leading projects through to those participating in projects within the clinical setting. A considerable body of literature has been produced associated with these developments, although there has been comparatively little research conducted on any aspect of the quality agenda. This is all the more surprising given the considerable investment, of time and people, which has been associated with these initiatives. Interestingly, this absence of research mirrors the position in the private sector (Cole and Scott, 2000).

The recent introduction of clinical governance has, once again, placed the issue of health care quality at the centre of the management and clinical agenda. In this

both organisations. The participants were all directly engaged in the development of clinical governance, with many district nurses indicating a history of involvement in related projects stretching over a number of years. Specifically, respondents were involved in many of the aspects of clinical governance identified by the initial policy publications (DoH, 1998; Scottish Office, 1998). Included within this was responsibility for leading the development of clinical governance within a community setting, managing projects including clinical audit and clinical effectiveness, involvement in risk management activities and, facilitating the involvement of other community nursing staff in these initiatives. In one instance, a district nurse indicated she had little knowledge of these developments. In fact this perception resulted from uncertainty arising from the terminology as she was indeed involved with aspects of the agenda. In practice the level of involvement in these clinical governance activities was varied, presenting a continuum, with at one end support nurses dedicating the majority of their time to the agenda, and at the other staff nurses having a limited involvement in clinical governance projects.

A total of 20 respondents were included in the data collection. Eight of these were district nurses, the majority of whom had worked in the community between 5 and 10 years. All the district nurses were practice attached, caseload holders and worked with a nursing team comprising staff nurses and untrained staff. Of the three respondents drawn from the staff nurse grades, two had worked in the community between 5 and 10 years, whilst the third had been qualified for three years. All seven respondents representing the managerial role had extensive experience of managing the introduction of change in the community setting. The final two respondents were support nurses, one from each organisation, who provided specialist advice and training related to the agenda. Both had extensive experience of previous nursing and management initiatives and had been involved with clinical governance from the early stages.

The following table shows the respondents and Trust where they were employed. Although an attempt was made to ensure an equal number of respondents from each

Trust, this was influenced by the availability of staff, particularly staff nurses, involved in the initiative.

Post held	Trust 1	Trust 2
District nurses	4	4
Community staff nurses	1	2
Managerial role	3	4
Supporting role	1	1

Table1: Distribution of respondents by role and Trust

3.2.4 Data collection

The interviews were preceded by the collection and review of pertinent documents, from both Trusts, related to the management and the development of clinical governance. This included the clinical governance strategy documents, clinical governance newsletters, annual reports, CSBS reports and policy documents produced by the Scottish Executive. This process provided an overview of the development of clinical governance in each Trust and issues relevant to the community nursing service, for example the nursing skill mix.

Riessman (1993) states that there is no one method for undertaking narrative analysis with the important points being how respondents interpret things and how the researcher systematically examines these interpretations. Amongst the means for collecting narratives proposed in the literature are those of case studies and the use of interviews (Czarniawska, 1997; Llewellyn, 2003). The literature also notes concerns regarding the use of interviews to collect narrative accounts, including the potential asymmetry of the relationship between the interviewer and respondents (Czarniawska, 2004a). It was also suggested that the interview process may suppress narrative processes (Polkinghorne, 1988) however Mishler (1986), building on the fact that telling stories is a familiar part of the conversational process, suggests that eliciting narratives in the interview context is comparatively easy. To promote the processes of narration, Polkinghorne proposed that interviews be treated as a discursive process, with Czarniawska (2004a) suggesting that the interviewer invite

discussion and attempt to establish a symmetrical relationship between the parties involved in the interview. Furthermore, Czarniawska (2004a) proposes that the conduct of the interview be based on recognition of the interviewee as an expert in their area who can provide a valuable insight into developments. In furtherance of this it is suggested, that the knowledge gained be recognised as being located with the interviewee, whilst the interviewer is depicted as offering time and attention. This approach recalls that of Strong and Robinson (1990), who treated their informants as experts in their field and used the interview for a joint examination of the management reforms.

With this in mind, the method used to collect data in this study was that of unstructured interviews, with the researcher concerned to promote an interview context which enabled the respondents to take some control over the interview process. Following from Czarniawska (2004a), Strong and Robinson (1990) and Polkinghorne (1988) these interviews were treated as sites for discursive interaction and also for recognising the expertise of the respondents. Therefore, the conduct of the interview was concerned with facilitating discussion through the use of open-ended questions and listening to the responses. Although inevitable asymmetries remained in some cases between the participants in the relationship with the researcher, as indicated by Mishler (1986) narratives related to the area of study were obtained from the majority of respondents with comparative ease. In some instances the interviews commenced with an initial question focused on the respondent's understanding of clinical governance, or their community role. However, awareness of the topic of interest to the researcher appeared to result in some of the respondents promoting discussion, commencing in some cases with the staff indicating a lack of knowledge of the topic of interest, a factor subsequently belied during the discussion.

In only one instance was a respondent somewhat reserved during an interview, admitting little knowledge of the initiative. However, following some discussion with the researcher, there was a subsequent flow of information and narrative related to the area of study.

The data collection commenced in 2002 and took six months to complete. Each respondent was contacted initially by telephone. Thereafter the respondents were advised of the study aims, objectives and methods to be used and their consent to participate in the study was obtained. The format of the interviews was also discussed with the respondents including permission to record the event. All of the respondents agreed to this process. Written information outlining the purpose, design and research method of the study and issues related to confidentiality of material was offered to the respondents, although only two nurses requested copies. The respondents were also assured of confidentiality by the researcher and given the opportunity to withdraw from the study; all agreed to continue.

The data were collected via unstructured interviews with each respondent's interview lasting approximately one hour. In all cases the interviews were held in the respondent's work location.

3.3 Analysis and interpretation

When organizational members tell their experiences to researchers and when researchers write up their work, they engage in narrative analysis (Llewellyn, 1999, p. 223)

This section details the processes of narrative analysis used by the researcher. Thus the interaction between the researcher and the research material are considered, and in particular, the means used to demonstrate rigour, transcribe the data, and finally the stages of interpretation and presentation.

3.3.1 Rigour

This qualitative research project uses the term rigour in place of the traditional terms of reliability and validity, to describe the criteria by which the quality of the study including the method, research design and findings can be evaluated. This choice was made due to the inappropriateness of using the positivist language and criteria associated with quantitative research, in the context of this study as a means of describing "good" interpretative research. Research in the positivist tradition presumes the existence of causal laws by which factual evidence can be provided.

This qualitative study is evidently not capable of producing arguments proving a causative link and backed by facts. Rather, this study is directed at the development of understanding and meeting the criteria identified by Barry and Elmes in which:

To be successful, authors must (a) convince readers/listeners that a narrative is plausible within a given orienting context; and (b) bring about a different way of viewing things, one which renews our perception of the world [...]. Together, these arenas form a kind of dialectic: extremely credible narratives tend towards the mundanely familiar, whereas highly defamiliarizing narratives often lack credibility (at least when first introduced) (Barry and Elmes, 1997, p. 434).

To demonstrate rigour, Bevir et al. (2003) propose that the story provided by the research should be the most comprehensive explanation that can be put forward. It is evident that as such, validity in narrative analysis is not an absolute, being instead derived from a consensus concerning what is real and perceived to be useful and meaningful for action. For Polkinghorne (1988), the term validity retains the meaning of well grounded and supported conclusions, which are evidenced through the strength of the analysis. Interpretation and reliability refers to the dependability of the data and the trustworthiness of the transcription process. A point of some concern was raised by Polkinghorne related to the importance of avoiding a cumulative suppression of certain narrative themes, which may occur during the interview process and also during transcription.

With reference to Polkinghorne's statement that there should be the demonstration of an explanation through the narrative research process, Lincoln and Guba (2000) stress that the research findings produced in this tradition should aim to meet criteria of trustworthiness and authenticity. This is achieved by ensuring that the means of data collection, transcription and interpretation of the findings are available for others to view. It is also important to indicate the stages of the research process and the choices made by the researcher.

3.3.2 Transcription and data analysis

Facilitating the rigour of the findings requires that care and attention to accuracy be taken whilst transcribing the recordings of the interviews. The majority of the interviews were transcribed by the researcher immediately after the interview, enabling the memory of the proceedings to inform this process and to assist in those instances when the respondents' voices on the recording were unclear. The immediacy of this process also enabled the initial stages of familiarisation with the content of the interviews and identifying points of interest for future consideration. Rigour was also promoted by playing the recordings taken during the interviews directly into *Soundforge version 4* a software programme used to convert the recording into an MP3 format. This allowed the recordings to be played through *Winamp version 5.02*, thereby facilitating the accuracy of the transcription process by enabling the accessing and replaying of minute sections of the interviews as required.

Three factors influenced the processes of preparing the transcriptions. Firstly the requirement for accuracy which, as indicated above, was provided for by use of software programmes during the transcription processes. Secondly, there was a concern with providing a means of searching the texts and finally, maintaining the narrative flow, readability and voice of the respondents. Initially this aspect was impeded by too much attention being paid to the coding of the interview texts and less to the content of the interviews. As noted by Czarniawska (2004a) the act of transcription is itself an act of interpretation; the approach chosen was concerned with producing a text which, whilst being used to identify narratives, also maintained the voice of the respondents. Thus the transcription drew from Czarniawska's approach which treat interviews as the "inscription of narrative production" (2004a, p. 55), rather than the detailed approach used by conversation analysis represented by Reissman (1993), which is described as viewing texts as "inscriptions of social interactions" (Czarniawska, 2004a, p. 55). The interviews were transcribed as standard written text, and the decision was made not to enter non linguistic material, for example, pauses and breath sounds. The voice of the respondents was also maintained by retaining their grammar, use of repetition and with punctuation used where possible to indicate the rhythm of the respondents' speech patterns.

Following transcription the texts were entered onto the *ATLAS/TI version 4.1* software; a package which provides the means of storing and analysing interview texts. This programme also enables the retrieval of data, searching across multiple texts and the inclusion of notes and other comments. Using this programme, a preliminary coding exercise was completed using themes which were identified during an initial reading of the texts. These codes provided a foundation for searching of the texts although, as noted, some disruption of the flow of the respondents' narratives arose from an initially overly zealous coding exercise. The decision was therefore made to restrict the use of the *Atlas* software to the initial coding exercise and thereafter as a search engine, rather than using the other functionality concerned with analysing the data. The texts were also saved as *Adobe Acrobat Professional version 6.01* files providing a means of retaining awareness of the narrative flow of each text and of counteracting the evident fragmentation resultant from the coding system and numbering arrangement in the *Atlas* software. In the subsequent analysis and interpretation use was made of both these formats, although the primary reliance was on the texts held in the *Adobe* software, with *Atlas* used in the main to search for particular instances of terms and themes.

3.3.3 *Interpretation and presentation*

To see keeping a conversation going as a sufficient aim of philosophy, to see wisdom as consisting in the ability to sustain a conversation, is to see human beings as generators of new descriptions rather than beings one hopes to be able to describe accurately (Rorty, 1979, p. 378).

It is argued that interpretation occurs at all stages of narrative analysis, or as Schwandt states "understanding is interpretation all the way down" (2000, p. 201). This is evident from the processes involved in narrative construction, where those listening to the narrative can only access their own interpretation of the meaning of the narrator, not the direct thoughts or meaning s/he intended to convey. These factors direct the interpretation of the narratives and the eventual presentation of the findings, which is evidently the researcher's interpretation of the findings.

To facilitate the reading and interpretation of narratives, Czarniawska (1997, 2004a) proposes the use of Hernadi's (1987) hermeneutic triad, which comprises three stages of explication, explanation and exploration. Explication is concerned with what the narratives actually say and translating these into the reader's vocabulary. Explanation considers why the text says what it does and finally, the processes of exploration state what the researcher thinks of the text. Each of these stages is in practice intertwined, although there are advantages to be gained from applying an apparently linear process to stages of the analysis, interpretation and presentation.

The initial stage of the interpretation was dictated by the need to deal with a large body of material, seeking to "squeeze an unwieldy body of discourse into manageable chunks" (Potter and Wetherall, 1987, p. 167). Therefore the interpretation commenced with reading and re-reading the texts to gain familiarity with the content and primary themes, including those related to clinical governance, the roles played by nursing staff, means of involvement and any other pertinent features identified by the respondents. From this process, an initial group of themes and key narratives were identified as occurring across the group of respondents. These were then used as a basis for a re-reading of the interview texts. This process was repeated on a number of occasions as part of an iterative process between the various texts, checking and re-checking how the various respondents dealt with the themes and the areas related to each theme which they had included or excluded. Narratives were identified on the basis of a storyline presented by a respondent with an introduction, explanation of events, action and some form of resolution (Czarniawska, 2004a). In practice the narratives were not presented as a discrete unit within an interview, but were developed throughout the process and intertwined with other plots and themes. These narratives were also found in some instances to be treated by a number of respondents, and occurred across various locations, indicating a degree of commonality in the nursing and organisational scripts. This process yielded a number of narratives that featured across the two Trusts and which were treated by staff holding the various nursing positions represented by the respondents. Some narratives were inevitably incomplete or treated by a single respondent; where this is the case these instances are indicated in the texts.

The second aspect of the triad is that of explanation, which is treated by Czarniawska (2004a) in terms of the use of subjective, objective or constructionist approaches. The means of identifying and analysing narratives selected by this study was the approach proposed by Burke (1969). This approach enables consideration of the means used by the respondents to construct the clinical governance agenda and develop the narratives, subsequently used to explain their actions and roles. The advantage of this approach was the provision of a framework and analytic which facilitated analysis across organisational settings and also enabled the representation of multiple voices. The examination of the texts was initially hampered by a failure to employ Burke's pentad, resulting in a multiplicity of constructions and the dominance of individual voices.

Finally, the third stage proposed by Hernadi is exploring the narratives, a process concerned with the researcher's construction of an explanation and the production of a research report. Reissman describes this process of story telling as:

what we do with our research materials and what informants do with us. The story metaphor emphasizes that we create order, construct texts in particular contexts (Reissman, 1993, p. 1).

Thus, as Czarniawska (2004a) observes, the research process is concerned with making the respondents' narratives available for others to consider and to demonstrate a logical and coherent flow. It is also crucial that the researcher's role as an interpreter of the data is indicated. The analysis presented by the researcher is a metanarrative constructed from the primary themes identified in the respondents' accounts. This process inevitably involved the researcher in making choices and whilst, as indicated by Rorty (1979), there is a moral privilege in the respondents' accounts, reflexivity is an inevitable and integral part of a study located in the social constructionist tradition.

Therefore, as noted by Czarniawska (1997) the study is a metanarrative; an act of ventriloquism on the part of the researcher, who uses a selection of material to talk on behalf of others. The metanarrative presents a polyphony of voices which have

been chosen to explain and promote understanding of the research issues. Essentially, the research process is an act of translation in which the researcher is not presenting the voice of the actors or respondents as these voices are not reducible to a single translation, and this is only one translation of the many which are possible (Czarniawska, 1999, p. 107). Therefore, the researcher invites others to reflect critically on the choices that have been made; on what is to be included or excluded; and also on how the data is presented.

This study presents the respondents' narratives within the framework proposed by Burke (1969), creating a metanarrative from the primary themes identified within the texts. In so doing, an explanation and exploration of the involvement of community nurses is provided, related to the initial development of the clinical governance agenda. This narrative includes extracts from the interviews with the respondents, selected on the basis of representing those narratives used to describe aspects of the agenda and processes. These extracts are presented verbatim except where the notation [...] is used to indicate that supplementary, redundant or repeated material by the respondent has been excluded. The respondent who provided the quotation is indicated with reference to their role and the Trust where they were employed, for example (Staff Nurse, Trust 1).

3.4 Summary

This chapter presented the chosen research method as lying in the interpretative tradition and drawing from narrative analysis. It has been argued that a narrative approach provides the opportunity to explore the involvement of community nurses in the clinical governance agenda, including the means used to explain their roles and the perceived impact of these developments. By using this approach the intention is to present an explanation or metanarrative, constructed from the respondents' accounts, which can then be used to inform staff, managers and educationalists involved in the implementation of the policy.

The following chapters present the metanarrative constructed from the respondents' accounts of the development of clinical governance in the community nursing sector.

instance, the situation is somewhat different as the stated intention is to integrate the approaches to quality and, also, to involve staff in the development of a corporate account for clinical quality (Scottish Office, 1998). Amongst the considerations for the health professions is the inclusion of the regulatory bodies in this national framework for clinical governance. Implementation of this agenda presents a considerable challenge for clinicians and managers, with the requirement to develop an organisational structure for clinical governance, involve staff groups and produce a corporate account for clinical quality.

The nursing profession is also required to participate in these developments at all organisational levels, by establishing the means whereby staff will be involved in the various aspects of the agenda. The area of interest for this study was the involvement of nurses in the delivery of clinical governance including also the organisational arrangements, and how the requirements for a corporate account would be interpreted by members of the nursing profession. Specifically, I was interested in how the nurses would integrate the requirements of this new agenda with their current nursing role and function and I chose, for my area of interest, the community setting. The rationale for this choice was to consider how community nurses develop clinical governance, given the comparative autonomy of this workforce and the less structured organisational arrangements. I was specifically interested in examining the perspectives of the trained nursing staff and managers who were involved in the development processes, thus enabling a view of how the agenda was being taken forward.

By examining nurses located in a clinical setting, this focuses the research on the contingent and complex context of organisational life. It is within this setting that nurses will seek to understand, discuss, interpret and participate in the development of clinical governance for community nursing. By identifying this organisational setting I was also guided by Bevir and Rhodes (2003), who note the absence of research on employees located at this organisational level in relation to the public sector reforms. They also commented on a requirement for research to be conducted that would explore the multi-faceted picture of several actors responding to changes

This narrative is presented within the framework proposed by Burke, with Chapter 4 introducing the context that the respondents create as the backdrop for these developments. Thereafter, Chapter 5 examines the acts into which the initiative is subdivided and the actors involved in these developments. Finally, Chapter 6 recounts the enactment of the initiative and concludes with the purposes identified by the respondents as those that the initiative was intended to achieve.

Chapter 4

Setting the scene

The following three chapters present the participants' stories of clinical governance as a metanarrative, using for this purpose the dramatisitic pentad proposed by Burke (1969). The stages of the pentad are divided into scene (Chapter 4), agents and acts (Chapter 5) and agency and purpose (Chapter 6). Presentation of the narrative in this way enables consideration of a number of factors including: the means used by respondents to construct their account of clinical governance; the balance between the constituent parts of the pentad; how the involvement of these nurses in this agenda is explained; and finally, the essentially performative nature of these accounts.

This chapter focuses on participants' accounts of the scene or context into which clinical governance is being introduced. Burke (1969) describes the scene as containing the acts and the agents, arguing that there is "implicit in the quality of a scene the quality of the action that is to take place within it" (Burke, 1969, pp. 6-7). The scene as constructed by the participants is not to be conceived of as a neutral and inactive context, but rather as providing a basis against which the events, actions and choices made may be explained. Examination of the texts identified three themes which underpin the descriptions of the scene. First, the processes of change including those occurring in response to the government led reforms of the health service, and the consequent impact on the role and governance of community nurses; second the language and dialogue available for the nurses to use; and finally, the third theme dealt with the context provided by the wider community of nursing staff. These three strands did not stand alone but were interrelated, calling to mind the concept of the "braided development of several story lines" referred to by Davies and Harré (1991, p. 49), and displayed some inevitable ambiguity between those factors used to describe the scene and the acts.

The following section considers the respondents' accounts of the changes occurring at organisational and professional levels, from which it is apparent that the

participants consider change to be a permanent feature of the working lives of community nurses.

4.1 Change as the new normality

Change is a recurrent theme in the participants' narratives, identified with political and management reforms, changes in the client group attended by the community nurses and concurrent developments in the community nursing role. Consequently, change appears to be a constant although, in the majority of instances, an unwelcome feature of the working lives of the community nurses. The majority of nurses interviewed also described themselves as having little control over these events and continually reacting to developments.

4.1.1 Organisational change and clinical governance

A number of the district nurses depict the development of clinical governance against a backdrop of recurrent change which is impacting on the NHS organisations. These developments are characteristically referred to in vague terms with a minimum of detail provided regarding the source, driving forces or specific goals that the change is intended to deliver. An instance of this is given by one district nurse who states that:

Organisational change is something that we come up against every couple of years and, every couple of years, we get a new set of people, telling us a new set of things and a new way they want it done (District Nurse 3, Trust 1).

Not only does this respondent associate these developments with unnamed people who are seen to impose inexplicable changes on the working arrangements of the community nurses, but she also sees this as part of a recurrent process. A sense of the inevitability of these processes is emphasized by the use of repetition throughout this description. A similar perspective is provided by a recently qualified staff nurse who had commenced working in the community setting. This nurse also presents change as a constant feature of nursing practice, although in this instance the factors driving

the change are identified and listed as political, legal and patient related. Thus change is said to be:

patient driven I would say, yes patient and probably politically driven, probably legally driven, probably economically driven [...] I mean we're in a more litigious society, aren't we? (Staff Nurse 1, Trust 2).

Although this respondent introduced litigation as a change factor, at no point in this account did she indicate any direct involvement in circumstances associated with litigation or indeed of dealing with any patient complaints. It is also notable that, for this nurse who acknowledged her comparatively short experience of working in the community setting, change was an accepted feature and indeed the nurse constantly referred to this topic. For another respondent, it is the constancy of change rather than particular drivers which is the area of primary interest, combined with the problems that this causes for the nursing staff. Thus change is depicted as the new normality which is not:

gonna stop you know. I've said that health it's not gonna change, you know, we're gonna always have this. So we've got to find ways of coping with the change (District Nurse 4, Trust 1).

Despite this perceived constancy of change and the requirement of learning to cope, there is little indication of management support being provided to assist with these processes. It is within this context that clinical governance is located as the latest in a line of politically driven initiatives and reforms of the health care system. For one participant, the introduction of this particular agenda is identified with the change of government and is driven by a new imperative, with the nurse indicating that it:

had to be set up. 'Cause as you know after '97 when the government changed, clinical governance became one of the major issues (District Nurse 4, Trust 2).

Clinical governance comprises a number of other initiatives, with one district nurse detailing these as follows:

I know it's a government agenda which the Trusts have to do you know [...] they have to do it. And they have to improve their standards, and meet their targets. And you know, it's to do with risk management as well and, reducing risk to clients, to staff, to them in the Trust. And to reduce risk of litigation, and [...] that's a huge bit (District Nurse 2, Trust 2).

Amongst the interesting features of this statement are not only the identification of the standards and targets as integral to achieving the goals of the agenda, but also the fact that these are completed by staff who are anonymous and identified simply as "they".

Whilst in this instance clinical governance is linked with specific projects including risk management, for another nurse the primary consideration is the locating of this initiative in a sequence of earlier programmes with the stress, once again, placed on the fact that each of these were also imposed on the staff group. The nurse also seems to indicate a cynical view towards these developments by likening them to fashion, signified by the use of the phrase the "in" word. Thus clinical governance is seen as the latest in a line of developments and by implication other developments will follow, with the nurse stating that:

when it was first imposed, I can remember thinking clinical governance what the heck's that? 'Cause we'd just had clinical supervision and we'd said oh [...] here's another thing, this is the 'in' word. And we do get things imposed on us all the time, I mean now it's Joint Futures. But there's never, I don't think there's many periods in the health service where we just merrily go along, the government are constantly wanting change (District Nurse 3, Trust 2).

The respondents also indicate that change is not only influencing the organisational context of community nursing service, but is also affecting the management of that service.

4.1.2 Changes in the management of community nursing

The participants associate these changes at organisational level with a series of developments in the community nursing client group, in the composition of the

community nursing team, and in the roles of district nurses and community nurse managers. There are also additional developments linked with the management of primary care. All of these factors are connected with the ongoing evolution in the role and circumstances of the community nursing service.

The first issue of note is identified with the early discharge of patients from hospital, resulting in an increased number of clients in the community who are suffering from “multi-problems” (District Nurse 1, Trust 2). The composition of the community nursing practice and caseload is said to have:

changed dramatically in that we have these complex care packages now. We don't have simple people on our caseloads anymore. The caseload dynamics have changed enormously because we've got people now that would have been in institutionalised care. So you're talking about heavily dependent people. That's exhausting mentally and physically (Manager 3, Trust 2).

The dramatic nature of these developments is forcefully conveyed through the opposition of the complex and depersonalised care packages now required, and the earlier circumstance in which “simple people” had populated these caseloads. Additionally, nursing this “heavily dependent” patient group impacts both mentally and physically on the nurses involved. For other nurses this transformation is related to the acquisition of new skills and knowledge, with one district nurse noting somewhat ironically that they have had to:

learn more technical procedures since I left the hospital [...] so you have to learn these in the community. And you don't have the backup of a ward, like if I'm doing it in somebody's home [...]. So you've got to be willing to actually put in the work, to actually learn the theory, to get the practical experience and, then make sure that you're absolutely 100% safe to practise (District Nurse 2, Trust 1).

The level of technical competency which is required is also associated with the fact that in the majority of instances the staff work alone and are relatively unsupported. This is identified with the tightening of training and development processes and consequent attendance at training courses for aspects of nursing practice that:

in the past you know you were very much shown by doing one under supervision and then let fly [...]. And a large proportion of what you go and learn on these days are the legalities of, you know, of what you're about to do to a patient (Staff Nurse 2, Trust 2).

Similarly, another staff nurse illustrates the changing ethos underpinning the use of research findings and the use of an evidence base for nursing practice, with:

you can't act or do anything unless you have [...] got experience. Whether it's like based on reports or research findings, you've got to know [...] how to tackle things and you've got to have ability to actually utilise the research that you read (Staff Nurse 1, Trust 1).

The factors covered thus far by the respondents were mainly concerned with the impact of these developments on the individual nursing role. Amongst one of the most significant developments was the gradual evolution of a skill mix in the community nursing team and the appointment of a staff nurse grade (McIntosh, 2000). Following from this, some district nurses have assumed an increasing level of managerial and administrative responsibilities for the community nursing team with whom they work. This is illustrated by one district nurse who describes the local nursing team as comprising:

a team of nurses, mostly part-time staff nurses, auxiliaries here. And we manage their ongoing development, very much like we identify things together (District Nurse 1, Trust 1).

For some district nurses these developments have not been without their problems, although the responses have varied with one nurse noting the reluctance on the part of some district nurses to change their role, especially in terms of delegating patient care to staff nurses. This is described as:

almost like a professional jealousy. And they're having to evolve, you know, with the changes. They're having to sort of, to appreciate this staff nurse knows what she's about, she's perfectly capable of assessing Mrs So-and-so (District Nurse 4, Trust 2).

The respondents associated this particular aspect with two other issues. Firstly, the escalating involvement of district nurses in a management role and function; and secondly, the associated problem of maintaining their clinical skills. A number of the respondents placed considerable emphasis on the idea that the role they are now performing is not the one they came into nursing to undertake. There is the suggestion in these accounts of the district nurses positioned between managerial and clinical responsibilities, in a hybrid position, with a frequently repeated story being the unwillingness to change their role. Thus a district nurse expresses the complexity of this position and the seeming unwillingness to engage in the management of staff:

I came into district nursing because I like to give hands on care. And I see our role changing so much in that we're managing you know. We're not managers, well we are, but having to manage, to do so much management stuff, and meetings and delegate things you know. I don't want to lose the hands on because I think the only way you can actually keep to grips with what the patient needs (District Nurse 2, Trust 1).

For this nurse the ability to perform the managerial aspects is of secondary importance to the need to maintain her patient knowledge, enabling her to get to grips with the patients' requirements. Another nurse explains that, under these new arrangements, she is responsible for assessing patients and delegating:

the work [...] to ensure that the skill mix is appropriate, you know that the person with the right skills is responding to [...] the patient needs (District Nurse 1, Trust 1).

The extent of these changes and the associated diminution of direct patient contact over a period of time is illustrated by a manager, who also somewhat ironically recalls her personal unwillingness to undertaking that role:

I didn't come into nursing with a view that I was going to come into management, I came into nursing to nurse patients. And the majority of district nurses do that, and that's one of the reasons why they would come out into the community environment [...]. Ten, fifteen years later 45% of your time is patient orientated. And 55% that's figures off the top of my head, [...] you know, they're linking in with the LHCCs,

they're linking in with the GPs, staff development training courses [...] they're taking this issue forward, participating in practice accreditation schemes. For example, quality practice awards are a lot of work for district nurses (Manager 3, Trust 2).

A considerable debate is evident surrounding these developments, with a dichotomy existing between the district nursing role and new management responsibilities. In particular, the gradual move towards a managerial function is perceived as problematic in terms of retaining patient contact and the necessary "hands on" care to maintain skills. The difficulties of this position and apparent tension being voiced by a district nurse in a series of rhetorical questions:

at what level are you becoming more a manager and less a hands on clinician? And at what point are you becoming like a consultant person rather than someone who does hands on care almost? But you still need to have the people there doing all aspects of the work (District Nurse 3, Trust 1).

However, the increase in management responsibility did not remain unchallenged by the participants with one describing some nurses as becoming too management oriented, "in a way they don't really want to do nursing" (District Nurse 1, Trust 2). This is further encapsulated by the statement that whatever debates surround these developments, if "you're not really involved in patient contact you are actually in a way getting away from nursing" (District Nurse 1, Trust 2).

These changes are perceived as having impacted negatively on the relationship between managers and community nurses, although the picture presented is disparate and fragmented. The management and governance of the community nursing service is presented as being in a state of flux; there is uncertainty regarding whether or not teams are self managed; and the potential isolation of the nurses from central and local management and other members of the health care team was observed. One nurse expressed the ambivalent relationship between the nursing team and line manager, describing a situation where they:

don't see our manager a great deal, and we're, I wouldn't say we're a self-directed team, but we are for the most part. If

there's a thing that I'm worried about I will, I'll go to her, if I feel out of my depth you know. I need support from my manager, as much as allowing her to do the job that she's there to do (District Nurse 1, Trust 1).

This relationship is presented as based on those areas where management support is required in exceptional circumstances, rather than for the day to day management of the nursing team. By contrast, the manager associated with this team was also interviewed and expressed less uncertainty about the status of the nursing team describing them as “virtually self-managed”, but also acknowledged concerns related to the increasing isolation of these teams. Thus a situation is described where a fragmented service exists and:

people became too insular, and we've tried to keep the locality concept as a team as well, so that it doesn't get too incestuous and not too isolating I think for people (Manager 2, Trust 1).

Despite this attempt to promote the concept of the “locality” the participants nevertheless identified an increasing degree of isolation from managers and other nurses. For one district nurse this is linked with the absence of a Trust wide forum for community nurses, through which they could hear about and discuss the latest developments. This factor is also linked with the failure to be aware of best practice:

I don't know what's happening. It used to be that we met quite regularly, but the G grades don't meet terribly often [...]. We tend to meet in our localities so I don't know if, we're certainly not sharing best practice in that way (District Nurse 1, Trust 1).

Isolation from senior nursing managers was also viewed as problematic, with this management group characterised as being distant from nursing practice and engaging more in talking down to, rather than with, the staff. This is summarised by one respondent who comments on the existence of one way communication, “there's a lot of talk down, and not enough what do people at the bottom actually say” (District Nurse 3, Trust 1). This nurse also adds:

in governance. Finally, the study was informed by MacIntyre (1985, 1988) who provides a narrative view, which points towards the performative aspects of narration within organisations and the probability that we are co-authors of our own story.

The co-authors in this instance were those nurses directly involved in the development of the agenda in the community settings of two NHS Trusts, in one health region. The respondents, drawn from the community setting, comprised district nurses, staff nurses, managers and those nurses involved in clinical governance support roles (Scottish Executive, 2000, para. 5) (hereafter referred to as support nurses). Evidently, other individuals and professional groups were involved in these processes of co-authorship, but these are only referred to indirectly by this study.

This research aims to understand the involvement in and contribution to the development of the clinical governance agenda of nurses and managers working in community settings.

Terminology

During the conduct of this research a degree of overlap was evidenced regarding the names by which the respondents called the various quality groups within their organisation. These included clinical audit, performance management, quality management and clinical effectiveness and, on occasion, the respondents were evidently unsure of the received nomenclature. Where possible the attempt was made to call groups by their correct name but, where this proved impossible, the group has been referred to as 'project group'.

Structure of the thesis

After this introduction to the area of interest and reflections on the use of a narrative approach, Chapter 1 outlines and discusses the literature on the NHS management reforms and the development of clinical governance agenda from various perspectives. It is argued that the impact of prior NHS management reforms on the nursing profession was comparatively under researched, reflecting the situation for

I think that would, that would probably improve the chance of success, if they involved people at all levels and not just considered that those at the higher part of the organisation are the ones with the opinions that matter. I think people much further down have opinions that really matter, that need to be heard (District Nurse 3, Trust 1).

A number of the respondents also referred to what was described as a failure of senior managers to recognise the value of work completed by members of nursing teams. This is illustrated by the story associated with a project concerned with the care of the terminally ill, which was detailed at length by two community nurses and one manager. The project had been completed by a nurse in the locality and the members of the nursing team had recognised it as a useful addition to the information available. This project was reported as having been rejected by the senior nursing management at Trust level. However the nurses themselves indicated that they were refusing to comply, with one staff nurse stating “I refuse to throw it out”, whilst a district nurse adds:

this wonderful project, and I still use it although [senior management] has told us not to use it. But it is a really good book. Now the [community nurse] spent a lot of time doing that and it was taken up to [senior management], and they just threw it out (District Nurse 3, Trust 2).

This nurse also indicated that she would not comply with all aspects of an administrative system being produced by these senior managers, and would not complete tasks “just to please people. We’ll do it; we’ll fill in forms if we see the necessity for it” (District Nurse 3, Trust 2). There are evident issues with isolation from the central management of the Trust, and perhaps this is the “incestuous” behaviour noted by managers. In this setting, the district nurses are also displaying the characteristics of “*street level bureaucrats*” as identified by Lipsky (1980, p. 3) in which the relationships with senior management are viewed as inherently conflictual and staff are concerned with attempting to maximize their autonomy.

The problem of isolation from the wider primary care team was also identified in terms of both geographical isolation and of exclusion from practice related

developments. The separation from other members of the primary health care team is, for some community nurses, a problem resultant from their location in a different building from the GPs to whom they are attached. This leads to problems associated with the integration of health care provision, although:

we work with the practice trying to have integrated services, but we're not terribly successful. We're in separate buildings, which makes things you know, more difficult, although we work hard at it (District Nurse 1, Trust 1).

However, even in those circumstances where the staff are located in the same building and the various professions meet at practice development meetings, integration is apparently an infrequent occurrence. As a consequence, the nursing agenda is perceived to be developing independently of the primary care team and:

the only time that we'd be together is practice development. And we're very much looking at the practice development, not the multi-disciplinary issues and we're kind of driving our own agenda, as I say, in there (District Nurse 4, Trust 2).

This relative isolation of the nurses is explained by one manager who cites the employment of practice nurses by the GPs as a major contributing factor. Consequently the practice nurses are seen as being directly involved in the developments with the GPs whilst other nursing groups, due to their different employment status as direct employees of the Trusts, are excluded from these changes. Thus:

the practice nurses because they work directly with them as employees, they will be helping them with that, but district nursing and health visiting are Trust issues, I think that's how they see it (Manager 4, Trust 2).

Finally, in a more humorous vein and yet evidently dealing with an issue of concern for this respondent, an account is provided of her attempt to inform a practice manager of the community nursing role, which although ultimately successful, required several attempts:

I came and said ‘hi’ and ‘did he know who I was and my areas’? And it was a while later that a couple of things that he had kind of asked about or spoken about, and I had to sort of ask him did he have any problems as to what my role was, or was there anything that he’d like to ask me? And he said ‘no, no’, and then when I asked him something, I can’t even remember what it was, he didn’t have a clue really you know. And it wasn’t like I was trying to insult him or make a fool of him; I was just trying to be helpful. But you know it was just a shame in certain things (District Nurse 2, Trust 1).

Not all of the nurses interviewed indicated that they were isolated from the activities in general practice. One district nurse recounted her involvement in working with a GP and with the manager for the locality. In this instance she was involved in a number of developments including the implementation of the Royal College of General Practitioners’ Quality Practice Award (QPA) (RCGP(S), 2000; Ring, 2002), a process also supported by the manager: “it’s just that we see that that’s the way to go, but the manager’s also very supportive about it and agrees with it” (District Nurse 4, Trust 1).

4.1.3 Clinical supervision

A final aspect of the change agenda, identified by respondents and specifically referred to by a number of the participants, is the implementation of clinical supervision for the nursing profession. Although clinical supervision was not formally recognised by the initial clinical governance literature (Scottish Office, 1998; DoH, 1998), its importance was recognised subsequently in the nursing strategy (Scottish Executive, 2001b) and so it is perhaps unsurprising that some participants directly link this initiative with the development of clinical governance. Clinical supervision forms a prominent feature in some respondents’ narratives, although it is not always expressed in positive terms with one nurse connecting this with the overall change agenda in health care, as yet another development:

we had change of government and there was gonna be Joint Futures and the whole thing, and clinical governance was up and coming, and clinical supervision was yet another thing that was thrown into the arena (District Nurse 4, Trust 2).

Clinical supervision is described by other nurses as an important process, concerned with improving nursing practice and also assisting nurses in dealing with change. One participant recounts her secondment to this project, describing how she and two other nurses are involved in implementing the initiative throughout the community nursing service in their Trust and providing appropriate training and development:

I look at the clinical supervision side of things that I'm very heavily involved in. I'm being seconded to that for six months, and that's at least another six months. I hope that will last a long time because I can see that lasting. Hopefully it will then take off (District Nurse 1, Trust 1).

Other district nurses are also involved as members of a clinical supervision team and indicate their responsibility for administering the process:

I always run the clinical governance, er sorry, clinical supervision meetings. So I'm the clinical supervisor if you like, and I do the documentation (District Nurse 3, Trust 2).

For a number of participants, clinical supervision is presented in a positive sense with involvement in supporting staff and in promoting their ability to look after and support each other. For one respondent, it is strongly linked with promoting a positive attitude amongst the community nurses by changing their attitude towards themselves, with this being achieved by using team building as a means of:

recognising our strengths and our weaknesses, umm, and supporting each other in that. So clinical supervision, I'd like to see more of nurses looking after nurses, looking after themselves umm and making that part of reflection part of everyday practice, instead of seeing themselves as low priority (District Nurse 1, Trust 1).

As well as rebuilding the confidence of nurses, clinical supervision is also presented as a means of dealing with the ongoing changes in community nursing and of assisting them "to think about their practice, to be reflective in their practice, to think how things can be changed and, why things should be changed" (Manager 2, Trust 2). It is also anticipated that this initiative will assist with the quality improvement agenda in health care, a process which draws upon the idea of reflective practice

(Schön, 1983, 1987) as a means of promoting improvement. Thus a manager comments on the benefits of providing nurses with the time and impetus:

to reflect on their practice. And obviously then that improves. Hopefully they'll be able to identify ways of improving their practice, or you know identifying learning outcomes or whatever (Manager 4, Trust 2).

This section considered those factors in the organisational structure which set the scene for the development of clinical governance. The next section examines the language and descriptions that the participants draw from and use in their conceptualisation of the clinical governance agenda.

4.2 Language and dialogue

Burke (1969) states that "when the curtain rises to disclose a given stage-set, this stage-set contains, simultaneously, implicitly, all that the narrative is to draw out as a sequence, explicitly" (Burke, 1969, p. 7). This section explores the language and models used by participants to define clinical governance, many of which are associated with initiatives that predate the implementation of this agenda. It is however apparent that defining and conceptualising clinical governance is a problematic process, with many of the respondents indicating difficulties with understanding the initiative. Therefore, this section commences with an overview of the problems which were identified and thereafter considers the use of metaphors, models and other concepts used to define this agenda.

4.2.1 *Clinical governance: defining the problem*

During interview, a number of the participants referred to the problem of defining clinical governance. This difficulty was identified as arising from the breadth of the agenda and the range of initiatives included under this heading. The problem is summarised by a nurse who states that clinical governance is "definitely hard to talk about it" (District Nurse 1, Trust 1). Similarly a manager also refers to attempts which have been made to define aspects of the initiative, stating that it is:

very difficult to describe I think to actually describe, although there's been lots of attempts with various Scottish Executive statements (Manager 1, Trust 2).

Despite these attempts to clarify terms, problems remain and the nurses are left with a breadth of potential interpretations. This, according to one manager, results in the initiative meaning "many things to many people" (Manager 3, Trust 1). A support nurse also discusses these problems but traces the difficulties to the word "governance" noting that although individual staff feel that they understand the term, in fact the meaning remains unclear:

Everybody presumes everybody knows what clinical governance is, and a lot of people just don't have a clue. Even the word governance isn't a good word. I don't think it means an awful lot, I don't know if it's an American word, but for some reason I associate it as an American word because of shared governance. So I think even that word is particularly difficult (Support Nurse, Trust 1).

In attempting to define clinical governance, many of the respondents refer to the range of initiatives which fall within the compass of the agenda, including research and development, clinical audit, standards, EBP, accreditation, risk management, and patients' complaints. Thus the breadth and inclusivity of the agenda is indicated, particularly by one manager who states "you can put anything under clinical governance really couldn't you?" (Manager 2, Trust 1). This factor, according to one manager, serves to complicate further the issue with staff tending to focus on either single aspects of the agenda or multiple parts, "depending on who you speak to, people [...] will focus on different parts" (Manager 1, Trust 1). This differing focus is problematic and makes it difficult to describe clinical governance. In response, a support nurse indicates a pragmatic approach, suggesting that the nursing staff do not need to understand the entirety of the project, nor is their knowing that they are involved in an aspect of the clinical governance agenda of any relevance:

when you talk about clinical governance to people, you just see them blank it over you know. Whereas if I can speak to them about a strand such as let's look at risk management, I might not even mention clinical governance. You know if we're talking about moving and handling here, we're looking

at introducing [...] a moving and handling risk calculator. Now they probably won't associate that with clinical governance. And I don't give a hoot [...] as long as they're doing it clinically right and they're protecting themselves (Support Nurse, Trust 2).

An opposing position, however, is adopted by another manager for whom awareness of the other aspects of the agenda is actively promoted with teams encouraged to decide where the priorities for action lie, as:

We wouldn't want people to be saying 'well you know we've got this ticked off, and we've got that ticked off, and therefore we don't need to be doing anymore in that area'. So we've tried not to be too prescriptive. But what we have asked is that the team [...] review their own activity and make statements about what they are going to work on (Manager 3, Trust 2).

Despite the varying positions and means of approaching the agenda, there is one point on which the participants were unanimous, namely the primacy of quality. Thus clinical governance is described as a framework for quality and concerned with pulling together a range of disparate projects:

it's about quality and improving quality from the NHS and it's a framework for quality [...]. And it involves different strands like risk assessment and audit, umm, complaints, they're very keen on that you know. And it needs to be, I think our care needs to be much more patient focused (Manager 4, Trust 2).

For another manager the term appears to be used not only as an organisational framework, in this case depicted as an umbrella, but also as a language used to integrate the various aspects of the agenda:

I probably understand it as [...] a language or it's an umbrella term. It's a broad term which encompasses lots of things to do with quality like clinical effectiveness, and risk management, and reviewing patient care, and ensuring good patient care, quality care is delivered (Manager 1, Trust 1).

Finally, a staff nurse in identifying the core of the agenda with the quality process, refers to the problems in conceptualising clinical governance, indicating that it could be viewed as an object, system, process and goal, leading to the view of clinical governance as a bit of a:

mish mash isn't it really? I mean it's a thing, it's a process, it's a theme, is it a solid thing? It's a process, it's a quality process, basically, by which we're looking for equity of quality throughout the service, and I think probably that's the best and most succinct way of describing it (Staff Nurse 1, Trust 2).

The final concept dealt with in this section is that of accountability. This concept is central to clinical governance (Scottish Office, 1998) but, interestingly, there are notably few explicit references to this by the participants with only one respondent actually defining clinical governance in relation to accountability. In this instance a comprehensive definition of clinical governance is provided as:

it's really corporate and, umm, personal accountability for clinical performance I think. [...] I think for me it's having the accountability at all levels, so that there is an overarching view of what is going on in one organisation, to ensure that whatever is in place filters down to all levels. I think equally it's reinforcing the need for every practitioner to be accountable for their own performance and their own professionalism (Manager 3, Trust 1).

Although this definition includes reference to both corporate and personal accountability, it is evident that, for this manager, the primary interest is with the former and in particular, with the development of an organisational framework to support and deliver the corporate account. Of the other participants who referred to accountability, the emphasis is different, with another manager indicating that she is less certain that the development of clinical governance has in any way changed the accountability arrangements existing within the Trust. The manager notes that although the articles:

all say clinical governance has made people more accountable, I don't actually get that feel in reality. I think the structure is there and I don't think it feels any different to be

honest [...]. You know the chief exec basically delegates it to the medical director and, maybe the director of nursing. And therefore it feels very similar to what it felt before. And I think people, certainly at grass roots level would not be aware (Manager 1, Trust 1).

Two other nurses also mention accountability, although in these instances this is with reference to their own professional accountability which is seen as a primary factor, particularly in the community where staff work alone:

because you're very much accountable. And if you are working on your own, we work a lot on our own, so we have to have you know high standards, because there's nobody looking over your shoulder to check you're doing the things right (District Nurse 2, Trust 1).

Finally, a staff nurse reviews the concept in terms of clinical governance and her own professional accountability with the former being viewed as, at best, a safety line comprising the use of protocols and evidence, but with primacy of place accorded to the clinical judgement of the individual nurse:

I suppose clinical governance in a way, it's not a safety net or anything. I don't want to say that it is a safety net. But it might perhaps be a safety line, to say well look this is the best type of practice, this, let's say a protocol, this has been shown to be really effective. We're not saying that it'll work for everyone, but it's been shown to be the most effective in the majority of cases. Here's your seatbelt use it. Sure your clinical judgement is over all of that, but you know I suppose it's a, it's a safety net (Staff Nurse 1, Trust 2).

4.2.2 Clinical governance: metaphors and models

The previous section illustrated the problematic nature of defining clinical governance. In order to overcome this difficulty the respondents frequently employed the use of metaphors, a method which is also evident in the clinical governance literature (Flynn, 2002; Pollock, 2004). There is a growing body of literature which considers the role of metaphors in the way we think, the use of language and the production of knowledge (Traynor, 1999; Llewellyn, 2003; Czarniawska, 2004). Metaphors have been extensively treated by analysts and philosophers with Aristotle

(trans. 1991) the first to identify the ways in which metaphors are used to produce knowledge. More recently, metaphors have featured in narrative analysis (Polkinghorne, 1988) and the study of organisations (Morgan, 1986); with the latter using metaphors to assist with describing the way organisations are, and as a means of discussing how they could be.

Metaphors have also been described as playing an active role in dealing with uncertainty, specifically by calling upon a hermeneutic process through which individuals apply their experience of what is known to describe and understand the unknown (Polkinghorne, 1988). The use of metaphors is described by Llewellyn (2003) as the first level of theorising used by agents in practice settings. Morgan (1986) also indicates the significance of metaphors in attempting to understand the source and nature of change and ultimately understand and manage organisations. Consequently the choice of metaphor can have implications for the processes of comprehending and dealing with developments. Importantly, Eco (1992) indicates that the usefulness of this trope is not without problems, arguing that metaphors focus attention on certain attributes of a subject and, as a result, other aspects of the image receive less consideration. From this it is evident that comprehension of a metaphor also involves an interpretive process. The audience is required to decide from which features of the metaphor the narrator is drawing, a factor determined in part by the context within which the metaphor is used.

The metaphor used most frequently by the participants and in the literature associated with clinical governance, is the description of the agenda in terms of an umbrella (Swage, 2000; Pollock, 2004). In the majority of instances, the umbrella is used as a means of describing the component parts of the initiative, the organisational structures and, in some cases, to indicate the interrelationship between the constituent parts. This use is evidenced by Pollock (2004), who employs the metaphor to present the organisational arrangements which have been put in place within an NHS Trust.

the rest of the health professions. There is, however, a growing trend of studies from other disciplines, including management and public and social policy, focusing on the impact of these reforms on the health professions, notably on the medical profession. This has resulted in a raft of descriptive studies considering: changing working practices; development of the general management role and function; and loss of professional autonomy. Whilst there is little published research focusing on the nursing profession, the positioning of nurse managers between the clinical and managerial settings has featured in a number of studies. The development of the clinical governance initiative was also found to have promoted a plethora of publications although many of the studies were, at this juncture, concerned with evaluating implementation. Finally, the chapter considers the centrality of the development of corporate and professional accountability to the agenda, although once again there was little published research or analysis.

Chapter 2 examines the theoretical perspectives of accountability to provide an understanding of the development of new forms of accountability from various standpoints, including professional, organisational and managerial positions. The calculative and instrumental models were thought to be inadequate by themselves to explore the involvement of community nurses in developing clinical governance. Therefore an approach considering the contested and contingent nature of accountability, and the active involvement of individuals in constructing this concept, was chosen as a means of conducting this study. Specifically, as proposed by Morgan (1986), MacIntyre (1985), Czarniawska-Joerges (1996) (hereafter referred to as Czarniawska, 1996), and Czarniawska (1997), an enacted narrative was used as this was thought to facilitate the capture of organisational and professional stories, as well as the performative characteristics associated with their narration. Based on these factors, a theoretical stance was chosen that emphasised the narrative and enacted nature of the development of corporate and professional accountability.

Chapter 3 sets out the ontological and epistemological issues associated with using a narrative approach, particularly in organisational settings. The chosen approach of

The umbrella has been used in Trust 1 publications to inform staff of the clinical governance programme. The majority of respondents were found to draw upon this metaphor, as was evidenced by a manager who described clinical governance as an overarching and hierarchical system. It was within this structure that the different aspects of the agenda and groups addressing these were located. This was described by the manager as:

we see it very much as an umbrella; there is the overarching clinical governance management group who take on the strategic overview of the way forward. Then we have the two groups for clinical effectiveness and service effectiveness [...]. Very clearly I think there's real links between them, although they sit apart there has to be overlapping cross fertilisation between those two groups, to feedback up to the overarching, clinical governance management group (Manager 3, Trust 1).

Importantly, the manager also uses the metaphor to demonstrate the potential that exists for linkages between the elements of the agenda and for cross-fertilisation to occur between the two identified projects of clinical and service effectiveness. This example also indicates the development of an organisational hierarchy for clinical governance, a factor identified by a community nurse who is managed by the manager quoted above and who also describes clinical governance in similar terms:

clinical governance to me is sort of like a big umbrella. It's [...] a real umbrella of how standards are and what's going on, and linked to clinical effectiveness. I mean it is just the overall umbrella, over it all (District Nurse 4, Trust 1).

It is evident that in most instances participants use the umbrella to refer to structural and organisational arrangements; although one respondent expresses doubts about this use and questions whether or not the projects included within this structure are indeed compatible. Following from this, the respondent suggests that the clinical projects be differentiated from those related to service effectiveness:

I think it's OK using the umbrella as a picture, but I don't think it's correct, I don't think that's the way it is. I think some things go together like evidence based practice, research, audit, they all go, fit nicely together. Clinical risk,

complaints, patients views, all that sort of thing are probably another clump as I see (Support Nurse, Trust 1).

Whilst the umbrella is the most frequently used metaphor, and particularly by staff working in Trust 1, other metaphors including those of jigsaw and iceberg are also used, although mostly to indicate problems with the agenda. In these instances the respondents used the jigsaw and iceberg metaphors to convey the image of hidden or problematic aspects of clinical governance. One district nurse used the metaphor of a jigsaw to indicate that, for her, the clinical governance agenda lacks a clear goal and is somewhat of a puzzle. The nurse develops this figure of speech by adding:

It's a jigsaw puzzle, though it would just be quite nice if it would just interlock in one picture, but I mean fundamentally it's broken into too many pieces (District Nurse 3, Trust 1).

Two managers also used this image to convey the problematic issues associated with the agenda. A manager in Trust 1 draws attention to the problems of fragmentation and importance of integrating all aspects of the agenda, in order to achieve the stated goals of clinical governance:

To me it's a bit like a jigsaw, and if you don't have one bit, or if one part is missing, then you are not actually achieving the aim, the whole that brings it all together (Manager 1, Trust 1).

Whilst in Trust 2, a manager also expresses the integrationist aspect of clinical governance, emphasising that the failure to meet all aspects will result in a failure to fit all the aspects together. This is expressed in terms of there always being the risk that:

you're really busy at one thing and leave something else behind them. You know that kind of [...] whole jigsaw, the whole concept kind of doesn't, doesn't fit together if that's the case (Manager 1, Trust 2).

The final set of metaphors used to refer to problems with the agenda, are those which liken the development to an iceberg and also to water. The iceberg is used as a means

of illustrating the scale and hidden depths of the agenda, with a manager drawing from this to describe her initial failure to comprehend all aspects of the development:

I mean clinical governance is more than audit, and it tends to be seen as just audit. I think that's [...] the sort of most obvious point, it's the tip of the iceberg really isn't it? And I think that's the first thing that people have kind of latched on to, and I think in a way that's the first thing I latched onto with it. And you know, as I'm learning more about it, I realise it's much more of a holistic picture (Manager 3, Trust 2).

Finally, a more subtle use of a metaphor is proposed by a staff nurse who describes the initiative in terms of water. Here it is suggested that whilst it is impossible to describe the agenda and pin it down, the actual processes of clinical governance underpin all aspects of nursing practice:

I think it's pervades everything you know. It's not just you look at one thing and say, [...] oh that's clinical governance over there, you can't, nobody can pin it down like that. It's a bit like water isn't it? It flows everywhere and you can't pin it down, it [...] should and probably correctly pervades everything I do, and I come in and say well what you know, what is my drive here? Am I trying to give the best standard for everyone and, if I'm trying to do that how will I measure that, how am I going to ensure that I give the same excellence of standard to everyone? That is probably what I would take out of governance (Staff Nurse 1, Trust 2).

From this overview of the metaphors drawn upon by the respondents, considerable variation in use is apparent. The umbrella is used to refer to structural attributes within the organisation; water refers to the processes which underpin the initiative, whilst the jigsaw and iceberg indicate some of the problematic issues. Finally, running through all of these is the allusion to the complex process implied by the clinical governance agenda of promoting integration between the constituent parts. Although, apparent in the above examples, integration is rarely discussed in the clinical governance literature.

In addition to metaphors, another means of conceptualising the initiative is through the use of models. Interestingly, despite the respondents' evident difficulties with conceptualising the governance agenda, they showed surprisingly little recourse to formal models to assist. In only one instance did a respondent refer to the use of a model for clinical governance, which was intended to explain the initiative and to aid with implementation. This model had been developed by a manager and the medical director, with the resultant model termed 'the matrix'. This model could be used in two ways: first, to examine the interrelationship between different aspects of the agenda; and, second, to enable comparison between current practices and the requirements of clinical governance. The matrix was described as a means of getting:

people thinking about what they're doing, and to look and see if they've any gaps or other areas where [...], they are already working on closing the loop in terms of complaints, but not doing an awful lot of other activity in clinical effectiveness for example (Manager 3, Trust 2).

Although other models were not evidenced by the respondents, there was some indication of reliance on patient pathways as means of promoting clinical governance activity. Patient care pathways were in use in both Trusts and the incorporation of their use into the clinical governance agenda was described as being potentiated by the actions of the CSBS. This had, according to one manager, changed the focus of the development of clinical governance:

So we looked at that way of developing [...] care pathways before in fact the Clinical Standards Board. And to me probably as a manager, probably as a clinician, [that's] the easiest, a very easy way to actually look at what happens in primary care. And that kind of the journey approach and [...] the sort of stages en route and saying well you know, can we make this better, or do we have to do it this way? (Manager 1, Trust 1).

Furthermore, the manager added that these processes are now being "driven by experiment and developments i.e. Clinical Standards Board, you know practice accreditation".

4.2.3 *Quality and standards*

In the majority of instances the respondents placed quality at the centre of the clinical governance agenda and identified it as either a driving force or the aim of the initiative. The difficulty of associating clinical governance with quality, due in part to the number of definitions of quality available in the literature, was identified by a manager commenting on the problems of definition:

I suppose it's kind of about how many different definitions are there of quality, and it's almost coming back to what clinical governance is all about, in that there are many perceptions and many aspects (Manager 1, Trust 2).

This section reviews some of the definitions of quality offered by respondents, comparing these with the taxonomy of quality definitions provided by Cameron and Barnett (2000). This provides an overview of seven definitions available in the quality management literature (Bank, 1992; Cole and Scott, 2000). Although quality occupies a central position in clinical governance, there are differences in the definitions provided by respondents: ranging from quality viewed as the highest achievable good; as the best care achievable within current resources; or, finally, as an integral aspect of the professional role.

Amongst the definitions provided, one staff nurse states that quality should be set at the highest level, using the terms “excellence” or the “best standard” to describe the quality of care which all patients should receive, and adding “that is probably what I would take out of governance” (Staff Nurse 1, Trust 2). This description is similar to that described as an innate awareness of what is good by Cameron and Barnett (2000, p. 273) who term this a “transcendent” approach to quality. The nurse also indicates that this definition provides a professional and personal driver to the delivery of nursing care to always strive for a higher quality for the patient:

We should always be striving to give the best not just what works you know, and not maybe just the mundane. We should be saying well [...], what is it that we can do? And always driving for the best quality (Staff Nurse 1, Trust 2).

This emphasis on the provision of the best possible standard is reinforced by a district nurse for whom the delivery of a high quality of nursing care requires collaboration with the patient to develop a care plan. Interestingly, this example represents one of the few occasions when a patient was referred to by a respondent, other than in terms of a diagnostic condition or patient pathway. Cameron and Barnett (2000, p. 273) refer in their taxonomy to a “user-based” approach to quality, which aims to satisfy and meet the needs of the service user. This appears to parallel the definition of quality by this nurse:

I see it is as a kind of heading and there's lots of branches off of it all interlinked, but its kind of how I see it. As you know providing that care to the best possible standard and then sort of monitoring that standard, and communication being a big part of that [...]. I don't really think about it as being a word that we're use in our everyday thoughts, but obviously communication is the biggest part of our job. It's the most important part, [...] because [...] our nursing care plan that we have with the patient, we plan with the patient (District Nurse 2, Trust 1).

In the following example, a district nurse refers to quality as being set at a determined level which is measurable, providing for value for money and deliverable through the use of a performance framework. There are evident parallels between this and the “values-based” definition in which, rather than aspiring to the highest possible good, the goal is described as achieving affordable excellence (Cameron and Barnett, 2000, p. 273). Interestingly, it could also be argued that this statement includes elements of a “production-based” approach which is concerned with conformance to specifications. Rather than consider which of the two is most appropriate the district nurse refers to a programme of quality related activities, based on achieving this agreed determined level:

it's a means of ensuring that there's a quality of care, a determined quality of care being delivered, but also that the care that's giving good value for money, we're obviously in cash restraints and things like that. So it's to ensure that we're giving the right quality of care and at a, you know, an adequate resourcing level, that we're working within the resources that are available. And in order to monitor that, we work to a performance framework which will be reviewed on

an annual basis or more often if need be (District Nurse 4, Trust 2).

The final view of quality, evident in the respondents' accounts, was provided by both a support nurse and manager. The support nurse drew upon the definition of quality presented by policy statements (Scottish Office, 1998), in which the emphasis is placed on the development of an integrated approach as a means of involving all staff in these processes, whilst seeking to meet the users' needs economically. This is described as:

making sure that quality is at the heart of the NHS and that everybody is involved, that the Chief Executive is responsible for quality and, that everybody down to the portering staff and catering staff feel involved in providing a good quality of care (Support Nurse, Trust 1).

Similarly, a manager also refers to the policy literature when describing the kernel of the initiative as "about continuous quality improvement and continually redeveloping and, it's never something that actually stops" (Manager 1, Trust 2):

you can have guidelines to follow informing of best practice in specific individual things. But [...] I don't think we can be too prescriptive about how we achieve that, because the people who've written the guidelines have to really understand the processes, the procedures, the whatever are not there in that individual circumstance. So you know there has to be a need to embrace that within the whole philosophy of care for that area (District Nurse 3, Trust 1).

Both of these statements evidently bear similarities to the "production-based" and "values-based" approach but, following from Cameron and Barnett (2000, p. 273), are also "systems-based" and intended to achieve the use of accepted quality procedures and processes.

4.3 "The Others"

A specific feature of the respondents' narratives is the treatment of the majority of the community nursing staff, descriptions of whom assist with developing a context for clinical governance. There is an obvious ambiguity here as the respondents are

evidently members of both groups. Burke (1969) notes, that although other characters provide part of the scenic context, they are also involved in the subsequent motivation of particular actions. Thus:

the characters, by being in interaction, could be treated as scenic conditions or 'environment', of one another; and any act could be treated as part of the context that modifies (hence, to a degree motivates) the subsequent acts (Burke, 1969, p. 7).

This is evidently an ambivalent relationship, particularly considered with Czarniawska's observation that "The Other" may be "a deviant version of ourselves" (Czarniawska, 1997, p. 4). Therefore, whilst the behaviour of this group is used as a means of explaining and justifying the participative role of the respondents in the clinical governance agenda, in some instances the respondents may also hold the same opinions as the nursing majority. Thus the role of 'the others' can be considered as a narrative device, used to explain the actions and decisions made by the respondents.

The wider group of community nurses form an extensive part of the respondents' narratives and are related, in particular, to a number of issues that are viewed as problematic for the subsequent development of the initiative. These include description of the 'the others' as being: afraid of change; lacking interest in these or other developments; and as lacking the time to engage in clinical governance. Somewhat paradoxically, this group is also described as being interested in clinical governance.

4.3.1 Fear of change

The fear of change is a frequently used description, in particular those changes related to current developments, with one manager noting that 'the others' are "frightened of some of the terms that they feel they don't understand" (Manager 2, Trust 1). A district nurse acknowledges the fear of change, providing a series of arguments explaining why community nurses should overcome this reluctance, and relating the core argument to the provision of quality of care:

A lot of people they don't like change, and you know they're worried by and threatened by change. But we have to move, things are changing all the time and we have to aim for the best standard of care. So my opinion is it shouldn't be seen as a threat, it should be very much trying to give quality care and good standard of care that's evidence based (District Nurse 2, Trust 1).

However, this nurse also adds an addendum to the argument, suggesting that those nurses who remain unpersuaded are "hiding something or you're maybe feeling threatened because you're insecure about something" (District Nurse 2, Trust 1). Fear of these developments is specifically associated with the monitoring of nursing practice by other staff members; a process whereby gaps in practice may be identified. As with the previous respondent, this district nurse describes the issue in terms of questions which the other nurses may ask, and provides a counter argument related to improving nursing practice:

I think sometimes people feel threatened by it, you know, they think are they trying to pick up on areas that I'm missing out you know? Will it show terrible gaps in my professionalism? Or you know, they view it with [...] an air of suspicion across the board, and they see all these audits and think [they're] checking up on me you know, big brother watching me, that kind of issue. Rather than looking at the positive side of things like you know, it will disclose areas where we could improve our practice (District Nurse 4, Trust 2).

The role of nurses monitoring the clinical performance of other nurses is mentioned by a district nurse who locates these developments in a wider organisational process. The following statement suggests Foucault's (1977) description of the panopticon with the increasing emphasis on audit and observation described as having:

a lot to do with other people kind of watching how you know. It's a relatively modern disease for the time (District Nurse 1, Trust 2).

This emphasis on watching and monitoring is also linked with the descriptions of clinical governance as a critical process and the development of clinical supervision. In the following statement a contrast is drawn between the new requirement for a

formal and critical approach and the informal processes currently used by staff. Once again the respondent couches her response in a series of questions which she has heard other nurses ask. Thus clinical governance:

It's got a critical kind of connotation about it that I think puts people off [...]. And I think clinical supervision smacks of the same thing, the terminology used, I mean 'cause people say and I mean I've heard, you've probably heard all of the things that people would say about clinical governance. You know it happens already, why do we need it? Why do we need a strategy? We can sit and we can talk and we can do it, but it's this for some reason incessant need to formalise everything that we do and write it down (District Nurse 3, Trust 1).

It is also suggested that increasing concerns with being monitored are compounded by the requirement that nursing practice be based on formal and critical processes and research based evidence. Therefore in terms of involving nurses in clinical governance, this staff nurse observes that:

The problem I see is that some people are only in here to look after patients, and that to improve the patient welfare you have got to read the research. So I think if you've got some nurses who've got like a fear, things can be made difficult (Staff Nurse 1, Trust 1).

4.3.2 Lack of interest

A second difficulty, identified by the participants, relates to the lack of interest which many nurses have in these and other developments. For one manager this is viewed as particularly problematic, having repercussions on the wider group of nursing staff. Specifically, those nurses who are considered uninterested are portrayed as wearing:

blinkers and will do their job, will do their caseload, and they won't look anywhere else and even if someone else is busy and they're not, it doesn't matter. They just focus on their own caseload and they're very insular. Which has a rebound effect on everybody else, and it increases pressure on everybody else. So yes, I mean I think there are issues across the LHCCs, that there are people who could be said to be under performing (Manager 4, Trust 2).

narrative analysis was explored and, informed by the concept of an enacted narrative and Burke's (1969) dramatisic pentad, used to conduct the research.

The findings of the study are presented in chapters four, five and six, using the format of Burke's pentad to present this as a metanarrative. These chapters set out the stages of enacting clinical governance in the community nursing setting within the pentad of scene, agent, act, agency and purpose.

Chapter 4 captures and presents the scene established by respondents for the development of clinical governance and their involvement in this agenda. The scene is found to be one in which a series of problems are introduced, which forms the basis and explanation of choices made by the respondents. This is presented as a compelling narrative of recurrent change in the health care setting and in the community nursing role. Within this context, the clinical governance agenda was introduced and presented in terms of the inability to clarify the meaning and boundaries of the initiative. Although quality was identified as being central to the agenda, mention of the concept of accountability was infrequent. Finally, the majority of community nursing staff was presented as disengaged, uninterested or too busy to be involved in these processes. Thus, the scene set for the enactment of clinical governance was found to present a number of problems for the processes of implementation.

Chapter 5 considers the agents or actors, and the acts into which clinical governance is subdivided and from which the community nursing account is to be developed. In identifying the roles within the agenda, the agents were found to be interested and engaged in these developments, in stark contrast to the presentation of the uninterested and disengaged nursing majority. The second part of this chapter describes the acts into which clinical governance was subdivided, namely standard setting and accreditation.

Chapter 6 considers the enactment of clinical governance by small groups of nurses who called upon a range of calculative technologies and persuasive abilities to

This picture of the insularity of some nurses is similar to the concern noted by another manager that “people became too insular” (Manager 2, Trust 1) in their nursing teams, which impacts on the other members of the nursing team. However, another manager suggests that the staff group find clinical governance “as dull as ditchwater” and view it as unnecessary:

they genuinely feel that they have they always give the best standard of patient care that they can. They always keep themselves up to date you know by keeping their education [...] at the level that it should be about, by attending all of the relevant sessions on whatever. And they just, they really do not see that this is necessary to the level that we’re churning it out you know. And they sometimes think, well really who pays attention to it? I sometimes wonder that myself from time to time you know (Manager 3, Trust 2).

In this instance, the voices of the other nurses are used to present a series of persuasive arguments to explain why they are not involved. Moreover, the manager suggests that she on occasion agrees with this viewpoint. Thus, ‘the others’ are “up to date” and are delivering “the best standard of care”. An emotive element is also suggested by the questioning of “who” is paying attention to the involvement of nurses in clinical governance. In a similar vein, another manager raises the point that in many instances these issues can for nurses seem:

to be quite trivial, but it’s not really trivial you know it’s important to the service, and it’s important at the end of the day to the kind of nursing care that you know the patients, clients, whoever are receiving (Manager 2, Trust 2).

This presents a complex backdrop for those nurses involved in clinical governance. Problems are not only identified at the level of the clinical governance agenda, but a number of respondents also refer to a lack of awareness of the “wider picture” on the part of some nurses, and in particular that of political developments. In this view, staff:

just come and do their job and just go away again and, and are not aware of the wider picture. And umm and I know everybody groans they hate the word clinical governance. Umm it doesn’t really mean a lot to them you know, they

just, to them it's just something else the government's imposed (District Nurse 3, Trust 2).

This seeming lack of interest is connected with a problematic situation where it becomes difficult to involve others, resulting in the prospect that clinical governance projects may fail:

It can sometimes be very difficult to get all members of the team signed up to what is seen to be the standard or the route that you want to take. And if people are not signed up and don't always accept the route that you are going, it can get very difficult then (Manager 3, Trust 1).

As is apparent from these accounts, although the community nurses are in some cases adjudged to be only interested in coming to work, the group, as a whole, hold a range of opinions related to the initiatives, with a district nurse noting that if they were asked:

what they understand by clinical governance? I think you would have half a dozen replies and varied. And what do you think it can do for you? I mean at the moment I think it would be extremely negative (District Nurse 1, Trust 1).

The difficulties with engaging staff are also associated with the language used to define and explain the clinical governance agenda, with a district nurse describing these difficulties in vivid terms:

I think the terminology used is very off putting and [...] so people are starting from a very negative point of view. So they've got a kind of battle on their hands to get people on board. I think they are, I think they are fully committed to it, umm, but I think they would equally admit that it is an uphill struggle getting people on board (District Nurse 3, Trust 1).

This statement also contains an apparent contradiction in portraying the staff as "fully committed" and yet there is "an uphill struggle" for those attempting to engage the staff in developments. This situation is summarised by a staff nurse who refers to the cliché that the developments will:

never happen to us [...]. That it doesn't really, it doesn't really affect us, nothing really to do with us (Staff Nurse 2, Trust 2).

4.3.3 *Time and workload*

Following from these descriptions related to the subjective and therefore less tangible attitudes of the staff, the respondents also recounted problems associated with the availability of nursing time and the pressures related to the community nursing workload. These topics were amongst the most frequently given reasons for the lack of nursing involvement. For one district nurse there was an apparent tension in the description of the time required to provide patient care, which subsequently left little time to become involved in other tasks:

My priorities here are to visit the patients and to get the work done, and most days there's not a lot of time left for anything else. As I say it's time [...] and I think that's the thing for a lot of people, their enthusiasm is there, the interest is there, but you just don't get the time (District Nurse 2, Trust 2).

Thus this nurse indicates that the staff are interested and willing to be involved but the failure to do so is outwith their control, a point also reflected by a support nurse for whom:

the biggest barrier for me for doing anything with nurses, is how do we help them to find the time? (Support Nurse, Trust 1).

An alternative perspective of this difficulty is provided by a manager who describes this issue from the view of the majority of nursing staff, indicating the difficulties which arise when staff are taken away from patient care, resulting in an increase in the workload of the remaining staff. This problem is associated particularly with having:

six district nurses sitting round at a meeting even every four weeks for a full afternoon, which is what it takes you know to actually get anything done. But that is a lot of manpower hours out of a service you know and, some poor devil back at

the ranch is you know left to take all of that afternoon's incoming referrals and so on (Manager 3, Trust 2).

A contrasting picture is also presented by the nurses involved in this agenda, who indicate that they lack both the staff and the time to undertake all of these tasks:

Basically they don't feel there is enough people to do the job, time for them to link to that, so that they can actually review standards and procedures, patient information (Manager 1, Trust 1).

One manager proposed that dedicated time should be provided for these tasks and this "should be counted as essential time and be a gradual sort of phased thing rather than adding on a few hours at the end of whatever" (Manager 2, Trust 2). This, it is suggested will stop nurses having to complete work in their own time. There are, however, other pressures on nursing time. In particular, associated with the need to stay informed of developments, an issue linked by some respondents to the amount of "paper" circulating:

There's too much paper, there's too much to read. We know it's important there's nobody saying that it's not, but there are only 7 ½ hours in people's working day or there should be, but there isn't anymore. The amount of stuff that my staff do in their own time is phenomenal (Manager 3, Trust 2).

This results in a situation where nurses are depicted as drowning in paper and having to prioritise what they will take the time to read. This is not only confined to the managerial and district nursing grades but extends to include the staff nurses, one of whom notes difficulties:

because there is so much paper for everybody, that you tend to prioritise. Oh the amount of paper, I came back on Monday and that's that [points at paper]. We do a round robin here and sign everything, and nothing gets filed or binned until everybody's signature on it. So that's the only way to keep up with it, really its ridiculous. So they had obviously read it and then it ended up in my in tray and then I switched it over there. But it is difficult to keep up with what's going on (Staff Nurse 2, Trust 2).

The implications of this for the development of clinical governance are noted in terms of the difficulties of eliciting comments on standards which have been prepared for the nursing staff in a locality:

I mean you can send out things to just everyone, you send out bits of paper to people, and they pick it up and they read the first part, and they toss it or they read it depending on how they feel about it (District Nurse 3, Trust 1).

Similarly, another nurse actually doubts that nurses looked at the standards which had been prepared, or at best may have given them what appears to be a cursory glance. The nurse notes how this situation is managed by stating somewhat pragmatically that they had their chance:

I don't think they ever look at them, I may be being bad here they probably looked at them when they came, and looked through them and didn't disagree with, because it was all sent to everybody before they were signed. So they all had their chance to say we don't agree with this, and I don't think anybody bothered (District Nurse 3, Trust 2).

4.4 Summary

The purpose of this chapter was to review and present the scene constructed by the respondents for the subsequent implementation of, and involvement of community nurses in, the clinical governance initiative. Although a considerable breadth of issues was used to construct this backdrop, central to this has been the theme of a changing milieu within which the community nurses are working. Overall, change is presented as causing a constant disruption of normal working practices and seeming to be, for the nurses, the new normality. The primary drivers for change are identified with forces external to the organisation including both government led and economic developments. The impression created is of impersonal and powerful forces driving this process and of the nursing profession having to respond to the policies which are being imposed. Overall, this creates the suggestion of *deus ex machina* in which the invisible and external hand of God is conceived of as acting off stage and moving the story of community nursing along to an unknown end.

The impact of these changes was detailed for the community nursing role, with particular implications identified for the district nurses and managers. The management and administration of the nursing teams were also portrayed as being in the process of development. This results in a lack of clarity regarding the boundaries of the respective roles and responsibilities. These narratives position the community nurses in an agenda where the scope for action constantly moves. For some, roles have become hybridised as represented by the increasing managerial and administrative focus of the district nursing role. Within this context, the introduction of clinical supervision is presented as one aspect of the change agenda, in which nurses have a degree of control over proceedings and a means of dealing with these eventualities.

Clinical governance is also introduced as another element of the change process, and as presenting particular problems related to defining and implementing the agenda. Notably clinical governance is portrayed as complex, with the respondents drawing from earlier projects and metaphors to define the aims and constituent parts of the initiative. Despite this apparent complexity there was general agreement that the central theme of clinical governance was a concern with quality, although this was difficult to conceptualise with varying perspectives represented including those at organisational, client and professional levels. Interestingly, the other theme identified in the policy literature, accountability, was only mentioned infrequently by the respondents.

The final component of scene setting was the extensive reference to the community nursing workforce and the problems associated with involving them in these developments. Thus lack of interest, fear and workload issues were presented as the main impediments to involving other staff in clinical governance. An interesting feature of this aspect of the narrative was the frequent use of a rhetorical approach with the questions which other nurses may ask, justifications and counter arguments presented in the course of the interviews by the respondents. Thus the respondents, as indicated by Burke (1969), appear to be developing a scene which serves as an

explanatory base for the actions taken by those actors involved in the development of clinical governance, and it is to these considerations that the next chapter turns.

Chapter 5

Naming the agents and the acts

The previous chapter examined the scene for the clinical governance agenda presented by the respondents. This chapter continues the presentation and examination of respondents' narratives, using for this purpose a further two aspects of Burke's pentad. These are: identifying the agents who were directly involved in clinical governance activities; and highlighting the acts into which clinical governance was subdivided. Identified in this chapter are the comparatively small group of nurses involved in the development of clinical governance, and the breadth of roles which they were described as enacting. As with Chapter 4, this chapter presents the stories and accounts provided by the respondents, dividing these under the headings of the agents and the acts; with the acts being subdivided into local and national standard setting and organisational accreditation.

5.1 The agents

Burke (1969) describes the agents as those individuals who perform the acts, in other words the actors who are concerned with making things happen. This statement indicates the close relationship between the aspects of the pentad and, in this instance, those of agent and agency. Therefore, in describing the characteristics of the agents, reference was made within the narratives not only to those skills and knowledge by which the agents were identified, but also to their use and hence to their agency. In order to maintain the narrative flow, it was thought to be appropriate not to adhere too closely to the differentiation between these two aspects of the pentad. Indeed, as Burke frequently observes, there is an essential ambiguity between the aspects of the pentad with, for instance, the agency of one actor providing the scene for another.

Although various policy statements (Scottish Office, 1998) assert that all staff are to be involved in clinical governance, this research identified only a small number of staff as directly involved in these developments. The agents were drawn from all grades of nursing staff and reflected the roles proposed by Scottish Executive (2000)

for the delivery of clinical governance, namely overseeing, delivering, practising and supporting. The research also indicates that a considerable part of the role of these agents was concerned with providing a means of involving other staff in the developments, or of representing the views of community nurses in the development of clinical governance systems. The enacting of the clinical governance agenda is considered in the following chapter. The range of activities, associated with this agenda, evidently has an impact on the means used to identify the agents and the specific skills, knowledge and personal characteristics they require. It is these factors which are considered in this section. However, the role of the manager was identified with delivering clinical governance, and a significant part of their role involved the identification of the agents. This obviously forms part of the agency of the managers and so, for ease of presentation and examination, the selection of agents and their characteristics is included in this section.

There was evidence of oscillation and hybridisation between the roles of the agents as described by the Scottish Executive (2000), and between the delivering and practising roles performed by managers and district nurses. Thus some district nurses were involved in decisions related to the delivery of clinical governance. This may reflect either the continuing development of the district nursing position or a blurring of the boundaries between the clinical governance roles, resultant from the knowledge and skills specific to implementing this agenda.

Three main themes were identified with the selection of agents: organisational and managerial factors; the personal characteristics or traits exhibited by the community nurses; and finally, the knowledge and skills required.

5.1.1 Organisational and managerial factors

The community setting was identified by some respondents as providing a context which facilitated the involvement of nurses in the latest developments. This was a factor associated with the working arrangements of the nursing team which, it was argued, enabled these nurses to exhibit more autonomy. This was explained by one manager with reference to management arrangements, suggesting that community

nurses held less responsibility for managing other staff, and were therefore able to address these issues by being:

a little bit more proactive. And I think that's something to do with the fact that they're [...], not managing such a hierarchy, and they probably feel more empowered [...] to be able to go off and do whatever they see is needed to be done (Manager 1, Trust 2).

A support nurse repeats the same theme, although in this case relating it to their ability to create the time and space required to assist with projects. This reiterates the topic of the precious commodity of time identified in Chapter 4, with the nurses in the community described as having:

more autonomy, and they're a bit more responsible for their own time, therefore they can make a bit of a window of time to do things [...]. If I'm looking for people to do help me with something I'll get community nurses (Support Nurse, Trust 1).

In this way, it is suggested that involvement is to some extent dependent on the agency of the individual nurse. Despite this apparent autonomy the nurses who are directly involved in clinical governance projects are comparatively few in number. In part this may be due to the primary determinants, described by respondents, of having an interest in this topic and being willing to attend the meetings. Thus the nurses involved in this agenda are described as the:

small group of people who turn up two, three times you know, [...] maybe half a dozen, who are stalwarts who are interested in that side the quality side (Manager 2, Trust 2).

The use of the term "stalwarts" suggests the resolute and determined nature of these nurses and implies that they are performing duties beyond that normally required by their roles. This is also implied by the description provided by a staff nurse who states "I think you will get the dedicated few who actually are doing clinical governance" (Staff Nurse, Trust 1).

deliver the corporate account. The means used by the nurses were found to span Bruner's (1986) two modes of cognition, the paradigmatic also known as logico-scientific and the narrative mode. The emphasis was placed, by the majority of respondents, on the paradigmatic mode with the use of EBP and audit systems. The respondents were also found to draw simultaneously from both of Bruner's (1986) modes in employing a range of persuasive skills when seeking to involve other staff in these developments. This study of the enacted narrative concludes with a review of the purpose of the agenda and perceived benefits arising for community nursing.

Chapter 7 presents a discussion of the findings, using relevant theoretical perspectives, in consideration of the accounts produced and the means whereby these were developed. The research demonstrates the continuing managerialisation of community nursing, with the majority of respondents found to represent managerial positions and to draw upon EBP. The primary means of delivering the community nursing account was through the use of calculative techniques, delivered by small groups of nurses, usually within a management framework. There was an evident emphasis placed on the production of accounts with a managerial orientation. Thus the accounts for community nursing were found to place less emphasis on the promotion of sharing and learning between clinical settings. There was also a narrative which presented a worrying discounting of the nursing profession, its history of involvement in quality management and, prospectively, its current role in the clinical governance agenda.

In conclusion, the chapter reflects on the implications of these findings for the community nurses, managers and further research.

Despite the identification of autonomy and personal interest as key factors in the adoption of this role, the managers were also found to be pivotal in promoting the involvement of staff. These managerial agents were described in a number of instances as being crucial to the process of delivering the agenda, and in particular enabling the involvement of other staff. One manager describes her part as that of “a doer” or “worker”, indicating by this her proactive role in facilitating clinical governance, providing direction for activities, creating organisational arrangements and thereby enabling other staff to become involved. Interestingly, the manager described herself as having no clearly defined role in clinical governance and consequently explained her position in more fluid terms as:

I suppose I'm one of the workers on the on the ground [...]. I'm suppose I'm making it work, I'm a doer yes, [...]. I mean you can't get involved with everything, and I suppose it's just making sure that the staff are given opportunities I think as much as anything else. So it's I think facilitating (Manager 2, Trust 1).

Although this description is couched in somewhat uncertain terms, other respondents offered accounts which stressed the part played by managers in promoting the involvement of other staff. Amongst these, the most frequently mentioned was the provision of extra time with staff acknowledging their reliance on the provision of additional hours to complete projects. Two respondents recount such a story from both the managerial and district nursing perspectives. The manager indicated her involvement in establishing a clinical audit project to rectify identified problems with nursing practice in the locality. This necessitated not only the provision of extra funding for additional nursing hours, but also the identification of a nurse to lead the project. The nurse was subsequently identified on the basis that she wished to work extra hours and, according to the manager, on the level of motivation the nurse was said to be exhibiting:

we had a district sister who is quite motivated who said that she was wanting extra hours, so we asked if she would like to start the audit, the nurse herself (Manager 4, Trust 2).

The nurse in question mirrors this account indicating the proactive role taken by the manager, who is depicted as having approached the nurse directly and asked whether or not she would:

be interested in working one day a week, would I be interested in carrying this out (District Nurse 2, Trust 2).

It is interesting to note that the primary emphasis here was the nurse's desire to work additional hours; at no point was her knowledge of the subject mentioned by the manager as a determinant for involvement. This is particularly relevant as the nurse concerned indicated that she knew nothing about clinical audit, standard setting or clinical governance, reducing the primary qualifications for the selection of this nurse to those of availability and personal motivation.

A staff nurse also recounts the circumstances surrounding the provision of extra time to complete a clinical audit project. The staff nurse had argued that successful completion of the project was dependent on this additional time, and extra funding was provided by the manager, to employ another nurse to take over the respondent's duties. However, during her account, the same staff nurse indicated a degree of surprise that the time was indeed provided:

I had to have time set aside for me to actually go and do that. I got given time, I got released to actually go and do it [...]. They employed a girl to actually come and take over my role for the day and, I went away and did my homework [...]. I had to ask them you know, but they did facilitate this because otherwise it wasn't going to progress anywhere you know. I think if you doing any sort of research or auditing you have to have time away in order to do it properly (Staff Nurse 1, Trust 1).

The provision of time was only one of the means used by managers to identify and facilitate staff involvement in specific projects. Another method of selection employed was the identification of nurses through their attendance at meetings. Thus, in the following instance a manager was described as exhibiting considerable influence over clinical governance processes, and selection of staff for involvement in a group which was re-writing the nursing standards for the locality:

at the last district nurse meeting [the manager] asked for volunteers to look at [the standards], all they've got to do is upgrade them, they've just got to get more recent references, 'cause they're all written they're not going to be changed as such. And she said I'm not leaving here until I get volunteers. (District Nurse 3, Trust 2).

The selection of volunteers for other projects is also recounted, with a district nurse explaining with some surprise how she came to be the clinical governance representative for her health centre. Accordingly, there were to be nominated staff for specific roles, including:

a clinical governance facilitator if you like for the GPs. And then they've got a person in each health centre, a rep in each health centre, which is really interesting because that's me (District Nurse 4, Trust 1).

Although this "rep" role was described as being created for each health centre in the locality, little explanation was given as to the rationale underpinning the selection process; although the nurse continues by noting that the representatives were "interestingly enough [...] all nurses". There is no indication given as to why it was this particular group of staff, if it was due to a perceived availability of time or of a particular position within health centres. The positioning of nurses in these roles is of interest given the stated concerns of some respondents, regarding the isolation of the community nurses from developments within the health centres. In this instance the nurse is undertaking a bridging role between the community nurses and primary care teams, although the nurse expresses considerable frustration related to her situation and to the lack of support from and solidarity with the staff in the health centre.

Overall the nurse summarises her assignment to this role as:

a total nightmare. I mean communication's quite difficult within the [...] the broader sense of the health centre. It's difficult getting people together, it's difficult to get consensus, and it's just very, very difficult (District Nurse 4, Trust 1).

5.1.2 *The interested few*

The level of interest exhibited in clinical governance and staff motivation, provides a recurrent theme in the descriptions of the agents. Although in some instances these descriptions are applied by the staff to themselves, they are also used by managers and support staff to describe the nurses involved in these activities. Interest in clinical governance is evidently an important factor in explaining the respondents' involvement. Moreover, it is contrasted in the narratives with the view of the nursing majority as uninterested in these issues, as illustrated in Chapter 4. Despite the emphasis many respondents place on this aspect, it is qualified in a number of instances with descriptions of other factors, which are seen to be driving the involvement of nursing staff. This position is tempered by one district nurse who identifies problems arising from constantly calling upon the interested few to take initiatives forward in community nursing.

In a description of nurses involved in clinical governance a manager terms them the "doers" and contrasts their actions with other staff who display little interest in developments. Thus a view of the doers is constructed by opposing the portrayal of the two groups of nurses, the interested and uninterested. Accordingly some nurses are described as:

leading and doing great stuff. I mean are taking a real initiative and being innovative. And [...] others it's someone else's job, and I'm going to get on with my own job thank you. A few of them [...] are actually really getting down to what we need to do, to really introduce clinical governance 'cause they've got a real interest in patient care and quality, and have an understanding of what clinical governance is. So they're really just starting and it's interesting to watch their enthusiasm and drive (Manager 1, Trust 1).

In identifying the interests of these nurses who are capable of "really [introducing] clinical governance", the manager describes these as existing across an extensive array of topics including those of patient care, quality and clinical governance. Furthermore, a district nurse notes that the successful implementation of clinical governance fundamentally requires people:

who are interested and motivated, you can't force people to do something, or to participate in something and give it their all (District Nurse 3, Trust 1).

This statement presents a view that the successful implementation of this agenda relies on volunteers or those who can be persuaded; although the respondents also indicate that staff are identified on the basis of other reasons, including what is termed the "willing horse syndrome" (Support Nurse, Trust 2). However, this nurse also notes the difficulties arising even for these interested few:

[The] one or two as I say are really keen who want to be involved, but because of their clinical commitments just can't be involved. And I think for others it's just time constraints, because more and more people want more of them (Support Nurse, Trust 2).

This respondent also indicates that not all nurses are involved on the basis of the level of interest, depicting other reasons, including those concerned with career development and others who may have been coerced. Thus project groups may be formed from:

one or two who drive the group you know, they've got a genuine interest in it. Others are there because it'll probably look good on their CV that they've been involved in it. And there's a couple of others there, who are there because they've been coerced (Support Nurse, Trust 2).

Despite this diversity within the groups, those driving the proceedings are in the majority of instances identified as being the interested participants. However, a pragmatic approach was found to have informed the decisions of two nurses who describe what they gained from their involvement. Firstly, a district nurse recounts how she originally volunteered to be a member of a group:

because we were told it was [...] we were told it was setting standards and it would be a short-term group. So I volunteered, I thought it would be interesting you know. I find if you go on groups that's when you find out what's happening in the world, and I find that you get a lot of information that you don't get if you're just going to the monthly meeting (District Nurse 3, Trust 2).

Thus involvement in these activities is viewed as a means of remaining informed of the wider context of health care, over and above the information normally provided for the nursing group. Again this contrasts with the portrayal of some of the nursing majority in Chapter 4 as having little interest outwith their own nursing role.

Secondly, a staff nurse presents a complex picture of the reasons underpinning her involvement, indicating both the need to involved and yet tempering this by expressing considerable reluctance. This is conveyed by her opening statement that:

when something like clinical governance comes along you just think you know, what difference is it going to make to me? There is that general feeling about a lot of these things and you can see where it comes from. But as I say I personally I've got too long left to work, I have to try and keep a handle on it, or I'll be left like a dinosaur (Staff Nurse 2, Trust 2).

Whilst staff interest has been identified as an important driver for involvement in these reforms, it also presents an object of concern for another nurse. This arises from the perceived use of the same nurses in taking forward initiatives and, as a result, creating:

almost an elitist band who take charge of all these issues. What you find I suppose and I would imagine it's maybe the same across all areas, is that you'll get certain district nurses or people who throw themselves on to practically every committee, and every band wagon that comes up. You know when they look for a volunteer the same old hands go up for everything, it's maybe time to try to encourage other people (District Nurse 4, Trust 2).

Furthermore, the nurse adds that although the use of small groups is perhaps "OK" for some projects, this is evidently not the case in the instance of clinical governance as all staff are required to take responsibility for these issues. Therefore:

it's not just for this small band to be addressing. It's something on the wider scale, everybody really needs to, I'm sure they do to a certain extent. But you know what it's like if there's willing people to go on these committees. Maybe we should try something like you serve a year on the committees and then the committee changes, so that everybody then has a

level of responsibility and experience, and builds confidence with the issues that are on board (District Nurse 4, Trust 2).

5.1.3 *Knowledge and skills*

The identification of agents has thus far been determined by organisational and managerial factors as well as the individual's level of interest. The following section considers the final aspect raised by respondents; that of the knowledge perceived to be required by those involved in this agenda. From the accounts, the range of interpretations suggests that there is an evident difficulty with defining precisely the knowledge and skills required. The accounts ranged from those who acknowledged that they had been entirely ignorant of the requirements of the agenda and, consequently, had few relevant skills to others, notably the staff nurses, who viewed the acquisition of these skills as an integral part of their nursing role and professional development. There was however a degree of commonality running through the aspects identified. This included the use of analytical skills; reference to the use of research; the use of EBP, audit skills; and finally, ensuring that the nurses keep up to date with the latest developments in patient care. In particular the managers were found to demonstrate a concern with the development of knowledge pertaining to critical analysis, including the sequential and critical processes of problem identification and solving. The view of knowledge taken is similar to Bruner's logico-scientific paradigm and also Morgan's (1986) conceptualisation of technocracy, in which knowledge is viewed as a rule based exercise, concerned with the ability to solve problems.

The skills of critical analysis were identified by two managers as being crucial to the processes of questioning and evaluating the delivery of care; and also to the examination of the evidence base for nursing practice. Thus a manager notes that it is crucial:

that from their assessment they can critically analyse just what is going on and what is needed [...] to evaluate what is going on. What is the care that's given? What could be done better or are there different ways of doing it? I think as well that it's important that they have the ability to look at

evidence based practice, and are continually auditing (Manager 3, Trust 1).

In a similar vein, another manager notes that clinical governance creates a requirement for nurses both to develop and use a critical approach to the delivery of nursing care. Thus they are expected to develop a background in research and audit; and to become more responsive to changes in practice by:

being up to date as far as guidelines, that type of thing is concerned. And reading articles, and looking at them, and critically analysing them. And seeing you know, is this highlighting an area in our practice that we should be looking at? (Manager 3, Trust 2).

This knowledge is depicted as spanning a complex array of skills, including those of questioning, learning to adapt practice in line with new evidence and articulating the basis of their nursing practice in terms of audit and research evidence. A district nurse adds another dimension to this by returning to a point raised by other respondents. Here nurses are aware of the wider context within which community nursing operates and have ideas as to how district nursing may develop:

I think you have to be someone that has, well you have to have a clear idea of district nursing and where it's going, and also have a lot of knowledge of what's needed. What you know, what is it that district nursing needs to look at. Because a lot of people have no idea (District Nurse 3, Trust 2).

From the perspectives presented above, it is evident that analytical skills are required, giving rise to questions as to how these are obtained. The respondents indicate that these skills are acquired through both formal and informal routes. It is also evident from the accounts that the staff nurses possess the research based skills most closely resembling those identified by the managers. From the respondents' accounts, it was apparent that the initially limited role of the staff nurses in these developments was now increasing, with a district nurse suggesting there should be:

more involvement of staff nurses in clinical governance issues. And that's going to come as a natural progression of the changes (District Nurse 4, Trust 2).

In particular one staff nurse is described as having been chosen to become a member of a clinical audit group on the basis of her level of interest. Additionally this nurse has relevant knowledge of this topic obtained through completion of a quality and audit module. The nurse describes this in terms of her "supposed knowledge as regards research and audit and all the rest of it, which was flattering but probably incorrect" (Staff Nurse 1, Trust 2). As well as this concern with quality related activities, she also highlights her experience gained from being:

seconded to the IT department for a few months umm, and I think she wanted someone not from the IT department, but with links in the IT department, so we could take some things back and say well, how about, how do we integrate this into the community system? [...]. I think probably I've a bit of knowledge as regards the process of audit. And a bit of knowledge as regards the IT department and computers (Staff Nurse 1, Trust 2).

In a similar account another staff nurse also relates the skills she has attained by completion of a degree programme, and which has led to her being selected to participate in a review of the nursing standards in her locality. Amongst the reasons provided for her inclusion the nurse refers to her ability to conduct literature searches:

I've got the IT skills to do the literature search that we need, umm so that won't be a problem I think that'll be alright [...]. I can see the relevance of searching the literature and, you know providing best practice. That's obvious isn't it? That's obvious to anybody (Staff Nurse 2, Trust 2).

The involvement of the staff nurses in these activities was found to draw from their completion of formal educative processes. In the case of those respondents who have been qualified for a longer period a different picture is evidenced. Thus a manager recounts how she moved from having little initial knowledge related to these topics,

to a position in which she is now able to critique the earlier systems for standard setting:

I used to think standards sound really complicated and, I used to look at these sheets and worry about how I was going to do all that. And of course now I just think you know they are just rubbish, I've moved on so much (Manager 4, Trust 2).

In a more detailed account, a district nurse recounts the processes which were involved in her transformation from a position of having been resistant to learning about this subject. Thus she exhibited some of the behaviour identified with the nursing majority. The nurse states:

at first I knew absolutely nothing. Because audit I think was one of these things, I think like everybody else that you know, I knew the word and I knew it was there, and I thought oh you know right, OK, switch off to that (District Nurse 2, Trust 2).

However, this position was changed as a result of her involvement in leading a clinical audit project, where the skills required were recounted as having been learned on the job, almost in terms of an apprenticeship system:

I really had to sort of learn that, I have learnt a huge amount from doing it. I learnt on my feet (District Nurse 2, Trust 2).

This story is similar to that recounted by a number of participants and goes some way towards explaining the stated concerns of other nurses with becoming involved in this agenda. A district nurse illustrates the awareness that, "to participate in things at whatever level there is a need to develop new skills" (District Nurse 3, Trust 1), adding:

that's not something that I would expect people just to be able to pick up and do, they would need to be trained to do that (District Nurse 3, Trust 1).

However, from the respondents' accounts it is apparent that the training and support available is piecemeal. This is illustrated by the varying positions adopted by the two

Chapter 1

A history of clinical governance

The stated intention of clinical governance was to place quality at the centre of the delivery of care and to correct the emphasis created by earlier reforms “on counting numbers, of measuring activity, of logging what could be logged” (DoH, 1998, foreword). Although an extensive body of literature has been published on the initiative representing multiple perspectives (Lim et al., 2000, 2001; Tait, 2004), the nursing literature has been “largely uncritical of clinical governance” (Watson, 2004, p. 38).

To identify the factors concerned with nursing involvement in clinical governance this review examines a body of literature representing professional, managerial and organisational perspectives. A search of nursing and management journals was completed using electronic databases including BIDS, IBSS, OVID, CINAHL, Emerald Management, Science Direct and SHOW. Amongst the literature identified and included in the review are government policies published 1983-2000, theoretical analysis and empirical research.

Drawing from this literature the review provides an overview of the NHS management reforms during this period, tracing the development of the quality agenda in health care, the role of the nursing profession and identifying the concepts that underpin the development of clinical governance. The review then turns to research conducted on the reforms, including those which focus on the nursing profession and the impact of government reforms on the health professions.

1.1 NHS management reforms 1983-2000

This section provides an overview of the management reforms 1983-2000, commencing with government policy for the period 1983-1991 (DHSS, 1983; DoH, 1989); then turning to the clinical governance policy framework (Scottish Office, 1997; DoH, 1997; Scottish Office, 1998; Scottish Executive 2000) and concluding with a brief overview of the management reforms and community nursing.

support nurses, one of whom provides training support for staff, whilst the other demonstrates that training and education are only provided on an ad hoc basis. The latter was also clear that this is not a significant part of her role and function. A manager in this support nurse's Trust however, reports on the results of a training needs analysis in which the need for clinical governance training and education had figured prominently in staff responses.

For many staff, learning on the job is evidently the primary means of gaining skills and the participants provided various examples, whereby they call upon the available experts working within the organisations. This was the route chosen by a district nurse who called upon a clinical audit specialist for assistance with learning how to use software programmes for analysis of data. In this instance the:

clinical audit officer for the Trust has been supportive you know and, umm when it came to transferring the data from a spreadsheet to a graph she went through that with me. So it was her that really taught me how to do that, and then I went off and did it all myself (District Nurse, Trust 2).

Instances of a more formal approach were also evident in Trust 1, with the example given of a secondment programme for some nurses, during which period they spent a day a week in the clinical audit department, gaining the skills associated with clinical audit. Additionally if these nurses have an idea:

that they'd like to explore further they can do a literature search and work up a proposal. So I think we are, umm you know, actually helping people to develop the skills slowly but surely (Support Nurse, Trust 1).

This programme was also referred to by a manager, who notes the range of specific skills that the nurses have acquired from working with the staff in the audit department, including the preparation and use of questionnaires and the conduct of clinical audit projects. Reference was also made to a formal training programme for the assessors who were to be involved in the RCGP accreditation systems; this was however perceived by a district nurse to have been inadequate:

from my personal point of view, I mean I don't feel it equipped me to go and assess a practice, which I haven't done yet. But I really don't feel the one day training that we did, I don't think that has really equipped me to go and assess them (District Nurse 4, Trust 1).

In an interesting exploration of the knowledge and skills required, a support nurse provided a detailed examination of the various nursing grades. The support nurse suggests that clinical nurse specialists provide an exemplar of the skills required to implement clinical governance, stating that "the people who do actually live clinical governance to a certain extent, maybe about 60 to 70% would be the clinical nurse specialists" (Support Nurse, Trust 1). These skills are viewed as spanning research, audit and the development of an evidence base for practice, with the nurse specialist putting these into operation by finding:

out what the evidence is, and to apply that, to look at risks, to think all that through, that's just part and parcel of what they do. They all do audits here regularly, some of them are involved in research (Support Nurse, Trust 1).

Having defined this role the support nurse then proceeded to subdivide the use of the knowledge and skills base across the nursing grades, creating a hierarchy of skills and applying these to all grades. The acquisition of these skills is presented as an integral part of a nurse's training and professional development. A view of the knowledge used in practice is also presented as being determined by the position of the nurse on the professional hierarchy, and therefore:

clinical governance for a D grade is going to be different than [...] that for an H grade. So, for example, if we take something like research [...], I expect clinical nurse specialists to instigate research, to define what the research questions are and to go out and find either if there is already evidence or research findings, to bring it to people's notice and to read it. E grades I would like them to start kind of looking (Support Nurse, Trust 1).

The knowledge used in the clinical governance setting is also depicted by one respondent as a double-edged sword, with an account given of the impact of a former member of a clinical governance group on the other nurses in this group. This nurse

was described as highly motivated, academically sound and capable of spending time seeking out information and evidence. The subsequent use of this knowledge was however viewed as problematic by her colleagues, resulting in a degree of alienation from her community nursing colleagues. Interestingly, this nurse was also described as having a weak knowledge and experience of community nursing, although the respondent also notes somewhat ironically that this would probably not impede her career development. This nurse is viewed as having created:

a feeling within the group sometimes that she could have run the group on her own. I don't mean that in a derogatory way, she was really, really hot, and could spend lots of time going off to the library and seeking out information, and everything you know. Umm but now that she's moved on and is not in that group, the dynamics have changed considerably in that everybody now feels quite able to come forward and maybe put their foot in it a few times and, maybe say things that are a bit. [...] It's just gives them a confidence now to be able to come to the group with ideas, and be able to vocalise their feelings on things a bit (District Nurse 4, Trust 2).

Morgan (1986) indicates that knowledge and control are inextricably linked with knowledge providing control over decision processes in organisations. As such, power is found to accrue to those who are involved in defining organisational systems. From this examination of the respondents' perspectives of knowledge, there are evident concerns and uncertainties over the development and use of critical analysis; and of promoting the voice of those nurses who are less confident in the use of these approaches. Thus the acquisition of the required knowledge veers from being something acquired 'on the job' through to its association with formal educational programmes. However, the enactment of clinical governance commences not only with the acquisition of particular skills and knowledge, but also with the inscription of a definition of clinical governance within the acts into which it is subdivided. The following section considers the acts in which these agents were involved, beginning with standard setting and moving on to organisational accreditation.

5.2 Act 1: standard setting

In an explanation of the dramatisitic pentad, Burke (1969) describes the acts as forming the central feature from which the other four aspects of the pentad radiate. Interestingly, Burke also states that the acts were not to be conceived of merely in terms of the deeds completed, but also in terms of what happened in thought. Therefore, identifying the acts is also concerned with processes of defining and establishing the boundaries and interrelationships and, in the instance of clinical governance, the means whereby the corporate and professional accounts are provided. The following sections consider the development of local and organisational standards and a history of standard setting by the nursing profession.

5.2.1 *Local and organisational standard setting*

The development and use of clinical standards occupies a central role in clinical governance activities and it is, therefore, unsurprising that they are the term most frequently used to describe clinical governance in the respondents' narratives. This centrality of standards to quality improvement activities is also reflected in the literature associated with nursing (RCN, 1981), the health service (Øvretveit, 1992; Dickens, 1994), and management (Cole and Scott, 2000). The concept also occupies a pivotal role in a number of quality assurance and quality management systems. In addition to acknowledging this centrality, some authors also consider the levels at which standards may be set and the professional, managerial and client perspectives they reflect, with Øvretveit (1992) referring to the difficulties in developing and agreeing standards. This section examines respondents' explanations of the acts associated with the use of standards, and refers to both local and organisational applications.

A perspective of clinical standards is provided by a district nurse who presents them as an integral part of the quality improvement narrative and central to the processes of clinical governance. Thus the stages are presented as a sequence of activities which commence with the setting of standards and proceeds through to a final phase when nursing itself becomes the object of attention and improvements in nursing practice are achieved. Therefore the nurse states:

clinical governance is well, just what I've said, is setting standards, auditing these standards and just looking at nursing itself and how it can be improved, that's really the way I look at it (District Nurse 3, Trust 2).

This extensive agenda is presented with an almost bewildering simplicity, emphasised by the word "just" which is related to both "setting standards" and "looking" at nursing. The centrality of standards setting to this sequence is apparent, although there is no indication as to who is setting these standards and at what level. However, one district nurse associates the setting of standards with the achievement of the highest quality, which would result from basing standards of care on research. Clinical governance for this nurse is described as:

obviously trying to provide a service of the highest quality of care, based on good standards of care that's research based. My understanding is that the care we provide should be the highest standard (District Nurse 2, Trust 1).

This can be viewed as a prospective or *ex ante* view of standards which provide a level of quality to be achieved. Whilst the above example indicates the use of standards to achieve quality of care, the following extract locates the use of standards within the clinical governance agenda as a means of providing evidence or an account of the performance of the community nurses.

I mean it has to be part of clinical governance in that you must, you know, we have to show that we can actually, that we are achieving standards, or that you know, there is evidence there to support what we are saying (District Nurse 3, Trust 1).

This example presents the retrospective or *ex post* approach in which the standards measure the care achieved. Thus standards can be both prospective and retrospective and appearing Janus-faced in their ability to look in both directions simultaneously.

In a further example a district nurse relates the use of standards to the provision of evidence, although in this instance the performance is measured in terms of resource usage and the process forms part of a formal management framework. The

framework is used to ensure that the nurses are able to provide proof not only that they are providing the correct quality of care, but that this quality is within an:

adequate resourcing level, that we're working within the resources that are available. And in order to monitor that we work to a performance framework which will be reviewed on an annual basis, or more often if need be [...]. And we look at all the different umm factors involved in maintaining standards, certain standards of care. We've reviewed all of the standards and that's in continual review, update, that [...] we look at certain clinical aspects (District Nurse 4, Trust 2).

This district nurse has identified the concern with maintaining, updating and reviewing standards and, in a continuation of this account, highlights the role of national standards in these processes. Thus SIGN guidelines are described as providing a means of maintaining local standards and of acting as an authoritative basis for the development of local nursing standards. These national guidelines are also presented as providing a prompt for the development of clinical standards:

on practically most areas of care. We have standards on the care of the diabetic patient, a lot of our standards are devised around SIGN guidelines. So if there's a SIGN guideline on a nursing issue say leg ulcers, wound care, diabetic care, care of the patient with a stroke, care of the patient with a catheter you know, all these different directives we've more or less got. We've got about fifteen up and running just now. I would say umm we're using a lot more tools, we're adhering a lot closer to SIGN guidelines on most clinical issues, so it's tying us not only into a local standard, but also national standards (District Nurse 4, Trust 2).

Although in this example the use of SIGN guidelines are used to prompt the development of local standards, the management process within which this is located is limited to the nursing profession and largely directed by the nurses and performance group members. In a contrasting account provided by a manager, the proposed means of setting standards should be formalised throughout the organisation, and concerned with achieving the three priorities signed up to by Trust management. These in their turn are based on three SIGN guidelines. Thus the organisational structures and staff activities are, according to this manager, focused

on the achievement of these standards. In her account she states a concern to preserve a “bottom up” process in which the voice of the staff is still heard:

I think the fear for me, is that in a structure, that we’re not driven too much from the top to say this is what the Trust is signed up to. This is what we’re gonna be measured on, this is how we’re gonna evaluate how effective our clinical governance facilitation and roll out is. Because it has to come from the bottom up too (Manager 3, Trust 1).

There is, however, a seeming contradiction with her view of a management structure concerned with ensuring that each locality develops a structure, comprising standards, guidelines and protocols; and which promotes a top down focus:

if the Trust are committing and if the clinical governance management group are signing up to specific SIGN guidelines, or clinical standards [...], we need to be very clear that we tie in completely with what the Trust is signed up to. So we know we’re not going off at any tangent. So we need to get the priorities from the clinical governance management group of what [...] guidelines the Trust are signing up to, to put out so that we fit in with that, that we don’t suddenly go off and do something else (Manager 3, Trust 1).

This section has reviewed the range of acts which the use of standards can encompass and the considerable breadth of usage identified by the participants. Whilst the acts inform the processes of clinical governance, the nursing profession also has a history of involvement in standard setting and this is seen to influence the construction of nursing involvement in clinical governance. The participants offered numerous references to this history throughout their accounts and the following section further considers the construction and use of this history.

5.2.2 A history of standard setting

The version of standard setting presented by the respondents is one which belongs to the nursing past. It is influencing both the future development of clinical governance and the involvement of nurses in this agenda. This section traces the transformation of standard setting from an initiative viewed as belonging to the nurses to one

involving other professions. From this account it is apparent that, despite the concern with the past, the picture of these nursing acts is on occasion discredited during the recounting process and the skills and achievements of the nurses involved are seemingly overlooked.

The historical context of standard setting is established by the respondents who refer to their membership of various groups, and the subsequent evolution of these groups. These processes of adaptation are outlined by one respondent who traces the standards, quality and performance groups within a locality which originally had a:

standards group who used to meet, I wasn't a part of it, and in actual fact when it was up and running I think I was still a staff nurse and studying for my degree at the time. And it was ongoing with a group of the already qualified district nurses. And they originally wrote the standards, when performance review, well not performance review, when the quality assurance group came on board which must have been about '98, '99 (District Nurse 4, Trust 2).

Another nurse provides an almost biblical account of the genesis of these groups, stating that:

before clinical governance we had standard setting, we had standard setting groups, I remember sitting on them (District Nurse 3, Trust 1).

Other respondents also illustrated their membership as spanning these various groups with the membership remaining the same in many cases, even though the groups may have been recreated or renamed. For one nurse their own continued involvement with the groups was due to the failure to persuade others to take on this role.

Consequently, this nurse's account creates a picture of having almost 'served time' as she was:

one of the first members, in fact I don't think there is anybody there that was an original member except me. Because when it changed its name we had the opportunity to leave, but there was nobody really wanted to take it on so I stayed (District Nurse 3, Trust 2).

The renaming of these groups features in several participants' accounts, illustrating the change from one initiative to another, although there is little indication that the groups changed their purpose. Thus the process is summarised somewhat dismissively as putting "things under new names", a procedure performed by the ubiquitous "they", who were identified by respondents with earlier reforms in health care:

we were standard setting there as well, I remember doing it there too, so its not that it doesn't happen. They put things under new names and reorganise them, and then that makes it very difficult for people to actually document what they are doing or put it under the right terminology. But it doesn't mean it doesn't happen in practice, its just not perhaps what people are expecting it to be (District Nurse 3, Trust 1).

At this stage, the groups in this locality were concerned with representing the interests of the nursing profession, usually at the level of local management. This situation was transformed, however, with the advent of clinical governance and the resultant metamorphosis of the group into a performance review group. This process was replicated for the other nursing disciplines, including health visiting and mental health nursing. This resulted in the district nurses having:

what was originally called a quality assurance group, which I was a member of, and which [...] set up our performance framework. And then it developed once our performance framework was actually in situ, the performance review group. The health visitors I think have the same sort of structure. And we look at all the different factors involved in maintaining standards, certain standards of care (District Nurse 4, Trust 2).

An interesting feature embedded within some of the respondents' narratives, is the apparent discounting of the nursing history in standard setting initiatives. Here reference is made to a range of factors which were seen to have limited the usefulness of these earlier systems, including the limited shelf life of standards and the distance of these systems from clinical practice, both conceptually and physically. This latter point is particularly apparent in the descriptions provided by a manager who portrays the author of the nursing standards as an isolated individual:

somebody just sitting there writing up all these standards like the [quality facilitator] used to do. You don't get much out of that, because it's written, it's stuck in a folder, and it's put up on a shelf and maybe you'll go and look at it for some reason or other. But I think it was more an exercise just to say that it was done, I don't think its truly related though to practically what you did on the ground (Manager 3, Trust 1).

The perception of isolation is reinforced by the use of imagery to portray the apparent placement of these standards in folders, on a shelf, seemingly out of reach of clinical practice. Furthermore, the production of standards is discredited by their depiction as a paper exercise, with little apparent relevance for clinical practice. The problematic nature of developing standards over time is referred to by another manager who tells of nurses talking about:

standards for a long time, and we had standards, we had a book of standards, a black folder of standards. I think, well I don't even know if I have got it in a folder under audit [...] because I threw a lot of them out, because they were so out of date it was just embarrassing (Manager 4, Trust 2).

In this instance the earlier standards are again perceived to be of little value, based on the problem of maintaining them and keeping them up to date, reinforcing the view that standards have a limited shelf life. What is surprising in these accounts is the fact that there is little appreciation of the earlier work or what was achieved, with the nurses seeming to wish to trace their standards and quality antecedents and credentials only to discount them. This lack of appreciation is a factor which seems to have transferred to the development of clinical audit, with one district nurse describing the lack of interest of nurses in the standard recently produced by the clinical audit group:

I mean you can send out things to just everyone, you send out bits of paper to people, and they pick it up and they read the first part and they toss it, or they read it depending on how they feel about it (District Nurse 3, Trust 1).

1.1.1 Management reforms 1983-1991

The genealogy of the clinical governance agenda has been traced back to the 1983-1991 management reforms of the NHS, and their implementation over the period 1983-1997 (Flynn, 2002; Harrison and Lim, 2003b). Although the NHS has, since its inception, been subject to a sequence of management reforms led by successive governments, the period 1983-1991 is notable for the scale and impact of the reforms introduced in the search for increased productivity, efficiency and improvements in quality (Harrison and Pollitt, 1994; Klein, 1995; Traynor, 1999). The publication of *The NHS Management Inquiry, Griffiths Report* (DHSS, 1983) is recognised as the beginning of the management transformation of the NHS, following Roy Griffiths' review of the "effective use and management of manpower and related resources in the National Health Service" (DHSS, 1983, p. 1). The resultant report diagnosed the NHS as suffering from institutional stagnation, slow and bureaucratic decision-making and the lack of a defined general management function. The findings "confirmed the diagnosis of institutional stalemate" (Klein, 1995, p. 147) between administrators and health professionals. Griffiths (DHSS, 1983) recommended that a private sector management model replace the former consensus arrangements and be used to drive forward change in NHS management. Although similar proposals had appeared in previous NHS administrative reviews (Harrison et al., 1992), the primary difference at this juncture was the seeming willingness of the government to enact the proposed changes (Pollitt et al., 1990; Harrison et al., 1992).

The primary focus of the reforms was to develop a single line for organisational control and accountability. This was to be achieved through the creation of a general management structure at regional, district and unit levels (Sutherland and Dawson, 1998), with the general managers assuming responsibility for organisational performance and achieving improvements in efficiency (DHSS, 1983, p. 12). These reforms had an immediate and profound effect on nursing with the profession losing much that had been achieved by earlier reforms. Notably, this included removal of the structure created by the *Salmon Report* (Ministry of Health, 1966), under which the profession had the right to be managed exclusively by members of the nursing profession and to have an automatic place on district management teams. Although

This lack of interest is not restricted solely to the nursing community. Other health professions are also represented as lacking an interest in nursing activities in this area, although as one nurse notes the nursing profession has been:

banging its own drum, and now finally other people are stepping on board and thinking that well maybe it is important (Support Nurse, Trust 1).

Although other groups may now be acknowledging the importance of quality issues there are apparent differences in how these are interpreted and the approaches taken by the other health care professions. Thus the earlier work by nurses in standards and quality is discounted by a manager, who conveys the somewhat patronising impression that other professions, notably the medical profession, permitted nursing involvement in these earlier projects. Quality is thus defined as:

very much as a nursing type thing, you know nurses will get on and do it, and the consultants and people might get involved [...]. But on the whole they just let nurses get on and produce nice little quality projects and standards, and they actually didn't get involved (Manager 2, Trust 1).

The manager continues by describing the new system which, in contrast to earlier versions, will be based upon the expectation that "everybody [will] sit and be reasoned and, work and provide standards" (Manager 2, Trust 1). Thus the new system is perceived to be a collaborative process, although the evident imbalance in the power each group can exert over developments is also indicated.

The imbalance of power is also referred to in the description, provided by a support nurse, of the various approaches used by different professions and the demarcation which can occur between the groups. In a detailed portrayal, the clinical audit and clinical effectiveness agendas are perceived to belong to the nursing and medical professions respectively. This situation gives rise to confrontation between the professions expressed by this nurse in terms of "wrest" and "drag" as they each attempt to "get in on the act". The basis of the problem, according to this nurse, is associated with the fact that in some hospitals:

clinical audit belongs to the doctors and doesn't belong to the nurses. In our particular Trust it's part of the nursing department so it belongs to nursing, and we try and drag the doctors into it. And clinical effectiveness, I think [a] very good thing has been that nursing has had to wrest it away from doctors and say no it is bigger than that. And actually we've got a lot to do with, it's something we are interested in so. And again I think there is separate history of it belonging to different groups and, now everybody else is trying to get in on the act (Support Nurse, Trust 1).

Following this differentiation between the various approaches utilised by the professions, a manager indicates that the nursing and medical staff have also developed different areas of interest. This differentiation is presented as spanning the quantitative and qualitative distinction, with the medical profession identified as interested in the tangible and measurable aspects of health care, whilst the nurses are concerned with the less tangible issues:

I think the medics will be focusing on clinical effectiveness guidelines, and ensuring that these parts are in place. I think the nurses are looking at the softer issues, the quality standards issues, ensuring that kind of patient information these aspects are being dealt with. So the nurses have a different approach, and they are much more focused on the things that would upset [...] patients. That's what they're focused on. What would be seen probably, traditionally, as the softer issues, but what in reality are probably the big important things to the patients (Manager 1, Trust 1).

The nursing approach to the quality of patient care is justified by reference to consideration of the patient's view on the important aspects of care. However, the new constructions or approaches to standards and quality are also determined by the ability to be involved in these developments which is, according to one manager, proving difficult in some instances for the nursing profession. Notably, an example is given which indicates that community nurses are excluded from clinical governance developments and their contribution to patient care, in particular the continuity of care, is overlooked. This situation has arisen from the existence of a "medical governance approach" in the locality, which is influencing not only the management of the LHCC, but also the development of clinical governance and clinical

effectiveness in the health centres. Thus the focus falls on the GPs and practice nurses and the manager recognises the benefits of sending these staff on courses to develop their skills in clinical effectiveness:

And that's great fantastic umm, because that'll improve care hopefully, and then we'll be able to sit down and look at the clinical effectiveness of what we're doing and, audit it (Manager 4, Trust 2).

However, there are problems with continuity of care arising from the failure to include community nursing staff in these initiatives. The manager observing there is:

Not one mention of district nursing. Now we see people obviously who are diabetic who tend to be housebound, and they tend to be medically complicated. Not one mention of district nursing (Manager 4, Trust 2).

The manager continues with the statement that she will take a proactive role in addressing this omission by preparing an explanation of the:

district nursing part and present it to them. Rather than just saying what about district nursing? It's like they can't think what a district nurse might do (Manager 4, Trust 2).

5.3 Act 2: organisational accreditation

The second act referred to by the respondents concerns the activities of those external agencies involved with monitoring the performance of the Trusts against national standards. These processes of accreditation were conducted in both Trusts by the CSBS (CSBS, 2001) and the RCGP (RCGP (S), 2000, 2000a; Ring, 2002). Quality accreditation as defined by the CSBS (2001) is a system of external peer review which uses written standards and is designed to assess the quality of an activity or service of an organisation. The respondents were involved with all stages of the accreditation processes occurring in both organisations.

5.3.1 Accreditation systems

The CSBS were involved in auditing the performance of the Trusts against clinical and generic standards, although the primary area of involvement for respondents was that of generic standards and, specifically, those standards related to the development of clinical governance systems. The Trusts were also involved in implementing the RCGP(S) practice accreditation scheme (Ring, 2002), which is focused at the level of the practice team in health centres. The implementation of both systems involved processes of periodic audit by teams of health professionals and managers. The CSBS used external assessors for this purpose, and the RCGP drew their assessors from those staff employed by the Trust who had completed an assessors training programme.

The respondents were involved in various aspects of these systems, although involvement in external accreditation systems was most evident in Trust 1. From the respondents' accounts the scale and impact of these two systems on staff in both Trusts was apparent. This was particularly so in the case of Trust 1 where the respondents indicated the impetus which both accreditation schemes provided for the subsequent construction of clinical governance. The primary area of activity, identified during the interviews, related to preparation for the assessment of performance against the generic standards produced by the CSBS (2001). The outcome from this was a comparatively high degree of visibility of the organisational accreditation processes for the majority of respondents drawn from Trust 1. The Trust managers also exhibited an awareness of the fact that the CSBS systems were in the process of development, and indeed the Trust had participated in a pilot study for the generic standards. Further, these standards were being used to promote the development of clinical governance across the Trust, whilst the RCGP system was being used for the same purpose in primary care. Thus the means of developing clinical governance in this Trust was dependent on:

looking at standards and kinds of packages of care, and making sure that the patient's journey, or the patient's episode is effective, that they are receiving effective care. And that's being driven by experiment and developments i.e.

Clinical Standards Board, you know practice accreditation, all these things (Manager 1, Trust 1).

Whilst the driving force for developments is identified with the CSBS and RCGP led systems, a manager also expresses the hope that there will be a process of reciprocal learning and sharing with these organisations, with the CSBS depicted as having learnt:

from us and we learnt from them you know, so I think there is some umm good learning going on, with people being involved on a wider scale [...]. I'm a wee bit umm concerned maybe about this accreditation approach. I think we've some influence, and I think we've already been able to influence them. I think there's been umm good consultation (Manager 1, Trust 1).

The respondents working in Trust 2 also refer to use of the CSBS system and, in particular, it is noted that the recent introduction of accreditation resulted in an adaptation of the clinical governance matrix to include this system. The impetus on this organisation was recognised as considerable, or as the support nurse adds "accreditation [...] came along as a big thing with the advent of CSBS" (Support Nurse, Trust 2). However, overall there is little indication of external audit having a profound effect on the development of clinical governance as was the case for the managers in Trust 1.

The introduction of accreditation by the RCGP was also found to have a significant impact with a manager noting that the implementation of this approach enabled the Trust to overcome the problem that:

we've never really managed to engage the GPs in a commitment for clinical governance. And one of the things that we have got everybody signed up to, is to look at practice accreditation (Manager 2, Trust 1).

A district nurse provides an account of her membership of a short life working group, established in the locality to look at the clinical governance agenda and to make recommendations on how to proceed with implementation. The working group

comprised a GP, district nurse, staff nurse and representative of the Allied Health Professions (AHP). It subsequently produced two recommendations: firstly, it indicated that the group was too small and therefore unrepresentative; and secondly, notwithstanding this viewpoint, the group decided to go with the:

Royal College accreditation practice accreditation, because it was already there, it was a way of measuring how we were functioning. And we did an audit of all the rest of GP practices to see where they would sit with their care in practice accreditation (District Nurse 1, Trust 1).

The decision was apparently determined by the fact that this system was already in existence; ready to implement; and provided a means of measuring how the GP practices functioned. The district nurse subsequently disagreed with this recommendation and noted the failure of practice accreditation to represent the wider areas of practice covered by the community nurses. It:

felt as if we weren't looking at us at all, because the minimum requirements for the Royal College practice accreditation is practice based, it's not the wider multi-disciplinary primary care team that we were looking at. So I felt in that respect we're missing out, we're not looking at the clinical effectiveness of the district nurses, health prevention, auditing things like that (District Nurse 1, Trust 1).

It is interesting to note the apparent gap between the view of the community manager and community nurse, with the former indicating the advantages of accreditation, contrasting with the district nurse who notes an apparent failure of practice accreditation to consider community nursing. A further gap is also referred to by another district nurse, who notes that clinical governance is wider than the GP's view which, it is argued, is solely identified with the introduction of accreditation systems:

the GPs actually see it as an accreditation QPA thing you know. Well I think it's big, I think it's bigger than that (District Nurse 4, Trust 1).

Another nurse, whilst indicating her lack of involvement and overall awareness of these developments, also presents a critique of the processes used to evaluate the performance of the Trust:

I mean various bodies come in and do varying evaluation of Trust performance against their set standards. And in my experience a great deal of that is looking at paperwork and looking at recording. And looking at how we are evidencing that we're achieving those standards. And it's a bit back to like the paper trail and, in my experience that's kind of what they are interested in, in terms of can we evidence what we're saying we're doing? Not necessarily are we doing what we're saying we're doing, but are we able to evidence what we say we're doing? And I think there's a difference (District Nurse 3, Trust 1).

This thoughtful analysis of a problem of accreditation systems points to problems which arise with interpretation of the assessment criteria. A similar point was raised by another nurse who had been selected and trained as an assessor for the RCGP practice accreditation. This nurse identified the limitations of the training process, including the observation that too little time had been available to train staff and to explore the disagreements which had arisen between trainee assessors. In one instance this had resulted in a failure to agree whether or not a GP practice should pass the assessment. The assessors included a practice manager and GP, and:

the practice manager was going to fail [the practice] and the GP was saying that it was OK. I think [...] you know, if there's a standard you have to go by it (District Nurse 4, Trust 1).

Despite being a comparatively new process organisational accreditation by these two agencies was also identified by managers as delivering a number of benefits, although interestingly none were outlined by the district nurses. Amongst the benefits was the promotion of a questioning atmosphere throughout the organisation, focused in particular on improving the delivery of nursing care. It was stated that the:

work of the Clinical Standards Board is good, it's raising awareness, it's making you sit back and look at what are we doing you know. Could we improve? Could we do things

better? Could we do things in a different way? (Manager 3, Trust 1).

This description appears to mirror the skills in critical analysis identified by managers as required by clinical governance activity. Amongst the factors identified was the use of the accreditation standards as a basis for the development of nursing standards. Again this appears to demonstrate a concern with building an overarching organisational system for clinical governance and calls to mind the use of the umbrella metaphor in Chapter 4. This is particularly evident from the role identified for the lead GP who is described as leading and promoting:

clinical governance and practice accreditation and trying to get practices engaged. Even if at a fairly low level at this stage, [...] working up to getting their practice accreditation up and running. And that's been particularly generated as a team effort, and supported by the Trust, the community staff, and the practices. And we would see setting the standards around that (Manager 2, Trust 1).

The suggestion was also made that the practice accreditation teams would provide a means of steering the implementation of clinical governance, with managers being:

guided by the sort of teams that are that are working in the Primary Care clinical governance team, that is looking at you know the practice accreditation visit (Manager 2, Trust 1).

However, a number of other problems with implementation of the accreditation processes were also identified, including the workload generated for the nursing staff, and in particular, that associated with the assessment procedures by preparing "three case studies for the district nurse" (District Nurse 4, Trust 1). Thus, a manager refers to the staff as spending "hours and hours and hours preparing the documentation and the input" (Manager 2, Trust 2). A viewpoint which is also mirrored by another manager who notes that:

participating in practice accreditation schemes for example quality practice awards, are a lot of work for district nurses (Manager 3, Trust 2).

It was also considered that this workload exerted considerable pressure on some managers as they attempted to meet the demands of the accreditation and monitoring process, with a support nurse describing one manager as being involved in a lot of:

fire-fighting in that the Clinical Standards Board are using us so much [...]. I think the [clinical governance manager's] fire-fighting and I don't think she's got any choice, it's because they keep saying yes to the Clinical Standards Board (Support Nurse, Trust 1).

Some support was available to assist staff, although this was limited to assisting the nurses in preparing material for these visits. Thus a support nurse describes her role with those:

individuals such as health visitors, district nurses who are involved in the QPA. They have come to me and said can you help us out? It's more of the bouncing ideas around how they can best present something for the QPA, for that particular wee part that they've to present for QPA (Support Nurse, Trust 2).

5.4 Summary

Chapter 4 demonstrated a view of community nursing in which change is constantly disrupting normality and has, in fact, become the new normality with which individuals have to cope. Clinical governance was identified as an aspect of these developments and specifically with the promotion of corporate and professional accountability and improvement in the quality of care. The accounts in this chapter demonstrated the identification of the agents who were involved in the development of clinical governance and illustrated the two primary acts into which the account was subdivided.

Although only a comparatively small group was identified as being actively involved in developing the clinical governance agenda, they represented all the trained nursing roles in the community. The characteristics by which they were identified were summarised by the epithets applied to these agents, including those of "doers", "stalwarts", "interested few" and the "enthusiasts". Thus they were presented as

having a degree of interest and motivation, and prepared to put in the extra effort over and above their normal duties. These nurses can be viewed to some extent as the polar opposite of the majority of nurses who were identified in Chapter 4. Thus these agents are depicted as capable of undertaking a role which requires the motivation, interest and knowledge to overcome the uninterested, fearful and busy nursing majority, termed 'the others'.

This energy and commitment was also associated with the apparent dependence on these members of staff who were able and willing to create the spaces and opportunities required for the various acts demanded by the clinical governance agenda. There was however a considerable involvement of various managers in assisting with the creation of these spaces.

These traits of character were accompanied by the requirement for, and use of, knowledge which was subdivided into practical knowledge and the use of critical analysis. There was considerable variation in how these skills were obtained: practical knowledge was acquired on the job or by formal secondment to appropriate specialist departments; by contrast, the staff nurses, all of whom had completed a degree programme, were assumed to have the foundation for undertaking activities related to the clinical governance agenda. However, a support nurse presented a limited view of the level at which staff nurses were to be involved. This contrasted with the actual involvement of staff nurses in the community, where they were involved in a breadth of clinical governance tasks. Whilst the support nurse may to some extent have been informed by a view of recently qualified staff nurses in the acute setting, one community staff nurse was comparatively recently qualified and had come directly to work in the community setting. The complexity of this debate was added to by the depiction of a district nurse who was described as extremely able, but whose skills in research and analysis had caused difficulties for other nurses.

Having identified the agents the chapter moved on to consider the acts into which clinical governance was subdivided. Two primary strands were evident: the use of

the newly created management roles were open to staff from within and outwith the NHS, the majority of appointees in the first round of appointments were former health administrators and treasurers, with less than 10% of the posts being filled by members of the nursing profession (Harrison and Pollitt, 1994). By contrast, the autonomy of the medical profession remained largely undisturbed (Klein, 1995), although attempts were subsequently made to involve medical consultants in responsibility for the expenditure arising from clinical decisions through the Resource Management Initiative (DHSS, 1986; Packwood et al., 1990, 1991; Harrison and Pollitt, 1994).

A significant feature of these reforms was the identification of quality as a topic of interest for managers, who were advised that: “[s]ufficient management impression must be created at all levels that the centre is passionately concerned with the quality of care” (DHSS, 1983, p. 15). However, at this juncture the impetus for quality matters remained at the advisory level and the managers were initially recommended to focus on consumer, rather than clinical issues by examining:

how well the service is being delivered at local level by obtaining the experience and perceptions of patients and the community (DHSS, 1983, p. 9).

Consequently, quality activity remained largely unplanned. The changing ethos of the NHS was, however, signalled by statements that managers were to be active in promoting change by providing a “driving force” (DHSS, 1983, p. 12), being able to “stimulate initiative, urgency and vitality” (DHSS, 1983, p. 13), and ensuring that the NHS was led from the “top by an energetic, new style of management” (DHSS, 1983, p. 19). Another notable feature at this time was the appointment of dispossessed nurse managers into quality related posts (Harrison and Pollitt, 1994).

The continuation of the government led reforms of the NHS was signalled by the publication of the *Working for Patients* (DoH, 1989) white paper, with the goals of developing service responsiveness and improved effectiveness. Quality resurfaced as a major theme of this reform, with the stated intention that “quality of service and value for money will be more rigorously audited” (DoH, 1989, p. 5), giving patients

clinical standards and organisational accreditation. It could be argued that these two approaches are interlinked and form two points in the quality improvement cycle. They were, however, separated in this chapter for ease of discussion. In identifying these acts the respondents were developing the means whereby the clinical governance account was to be provided. Whilst standards and the associated processes of monitoring are complex, amongst the various approaches identified were local systems of standard setting linked to management evaluation. Additionally, extensive reference was made to externally produced and authoritative standards, such as those produced by SIGN. These were used to provide an evidence base, as a prompt for standards setting and as a means of developing an overarching clinical governance system by linking national and local standards and monitoring systems.

The second identified act was that of the external monitoring bodies as represented by the CSBS and RCGP accreditation schemes. These provided for the monitoring of performance and in so doing provided a source for authoritative standard statements. The respondents indicated their involvement in a range of related accreditation activities, although some highlighted difficulties regarding the lack of representation of the community nurses in these systems. There was an interesting irony associated with the involvement of one community nurse in selecting the RCGP accreditation system despite the perceived failure of this system to represent the community nursing role.

Against the backdrop provided by these acts, the respondents also provided an account of the position of the nursing profession which was of the doer, undertaking a range of tasks energetically and with enthusiasm. There were however evident problems with making the voice of the nurses heard in these developments, with the medical profession seemingly dominant in many settings. The nurses provided an extensive account of the history of nurses in standard setting and other related quality initiatives, although an interesting feature was a discounting of earlier projects and performance. There was evidently an underlying construction of not only a clinical governance account but of a community nursing discounting.

Despite this there was little negativity expressed by the respondents in relation to their involvement in clinical governance activities, although some were pragmatic in terms of why they were involved, and perhaps their doubts were voiced through their portrayal of the nursing majority.

This and the previous chapter have set the scene for the enactment of clinical governance which will be considered in Chapter 6.

Chapter 6

Enacting clinical governance

This chapter completes the presentation of the clinical governance metanarrative by considering the final two aspects of Burke's pentad: agency or the means used to enact clinical governance; and the purposes or ends that the respondents indicated the agenda was intended to achieve.

The use of dramatism invites the researcher to explore language and thought as modes of action. By focusing on agency and purpose, this chapter is specifically concerned with the actions of respondents to achieve particular ends. These are identified with the processes of enacting, which are built on the use of hidden and shared everyday interpretative schemes within the organisational context (Morgan, 1986). Amongst the interpretative schemes in place in health care, clinical audit has been identified by the respondents as a significant aspect of the clinical governance agenda. Moreover, Power (1997) points to the essentially dramatic nature of the processes involved in organisational audit, which are said to have:

the character of a certain kind of organizational script whose dramaturgical essence is the production of comfort (Power 1997, p. 123).

According to Power's thesis, the comfort arises not only from the familiarity of the script but also the means by which it was enacted. Informed by these perspectives, this chapter examines the respondents' performance of clinical governance including the stages of identifying a script, selecting the cast and enacting the drama. Finally, the chapter explores the purposes or means achieved, considering also Burke's observations regarding the degree of ambiguity arising between elements of the pentad as noted in the statement that:

Implicit in the concepts of act and agent there is the concept of purpose. It is likewise implicit in agency, since tools and methods are for a purpose (Burke, 1969, p. 289).

In consequence, whilst a range of purposes and goods are identified by the respondents, some also feature in descriptions of the enactment of clinical governance as used by the agents to persuade other nurses to become involved in this agenda. Therefore the purposes are treated from the perspectives of desired outcome from the agenda and as a means of persuasion.

6.1 The play's the thing

According to Burke (1969), agency refers to the means by which agents choose to work and includes the use of language, knowledge and skills. Obviously the form that the agency takes will be determined by the choice of acts. In Chapter 5 these were identified with standard setting, clinical audit and organisational accreditation. The agency of the respondents was found to bridge these various acts, although a majority of the respondents placed particular emphasis on enacting the stages of standard setting and clinical audit projects.

In considering the enactment of clinical governance this section is divided into two parts, choosing the script and assembling the cast.

6.1.1 Choosing the script

The initial stage of the drama was concerned with agreeing a script or the topics to be addressed by subsequent clinical governance activities. The agenda as outlined in Chapter 4, demonstrates the extensive array of topics falling within the compass of clinical governance. It is therefore no surprise that the respondents placed a degree of emphasis on the processes concerned with identifying topics, whilst providing less detail related to the actual topics selected. Two mechanisms were identified: the first employed problem based approaches; and the second drew from framing devices to conceptualise and compare the clinical governance agenda with current practices. The narratives also portrayed the involvement of managers and support nurses in the processes of topic selection. A point of some note is that, despite the emphasis placed by some respondents on the development of skills in critical analysis, objective appraisal of these processes was evidenced by only a few respondents. Where relevant these observations are included in the narrative. Finally, although the

approaches to topic selection are treated separately in this section, in practice there was considerable overlap in their use by the respondents.

The use of a problem based approach is a commonly recognised means of undertaking quality improvement or quality management activities in health care and the private sector (RCN, 1990; Øvretveit, 1992; Cole and Scott, 2000). This approach places the emphasis on dealing with the exceptional events or disruptions to normality, which in this instance refers to those occurring in nursing practice. Characteristically, for the nursing profession this was associated with the creation of short life working groups, who subsequently addressed the issues through standard setting or clinical audit (RCN, 1990). As has been demonstrated by this study, the problems identified as providing a focus for clinical governance were proposed by those respondents who were managers or members of clinical governance groups.

A specific instance of a problem based approach was described by three of the respondents: a manager who identified the topic; a district nurse charged with leading the project group; and a staff nurse who was a member of this project group. The audit was prompted by a number of what were termed “near misses”, in particular related to the employment of bank nurses. This was said to have resulted in a:

few incidents to do with errors in documentation, which led to a couple of medication errors. I thought that we should be looking at our documentation and use this experience (Manager 4, Trust 2).

Following from this a district nurse was identified by the locality manager and nurse manager to lead a clinical audit project. The pivotal role of the managers in this process was also identified by the district nurse in question, who provided additional detail on the nature of the problem, described as resulting from the quality of nursing records being:

higher in some areas than others. And that actually led to in a couple of incidents, incident forms having to be completed because situations arose. As they were partly attributable to

the fact that the records weren't perhaps as [...] umm, I don't want to say of a high, but probably of a high standard that they should have been, there were ambiguities. So [the manager] along with [nurse manager], decided that you know possibly we should be thinking of clinical governance, that we should be auditing this and creating a standard for our nursing records (District Nurse 2, Trust 2).

The potential risk to patients evidently influenced the selection of this issue, as did consideration of the fact that the risk could be multiplied across the locality unless, it was argued, an agreed standard and means of documentation was developed for community nursing. As a result, the primary focus of the group was on the development and acceptance of a nursing standard related to a systematic approach to documentation. The purpose of the group can be characterised as being concerned with promoting a standardised approach to this aspect of nursing care.

Organisational arrangements were also in place to enable other staff members to identify topics by feeding ideas into a permanent practice review group; although in actuality this was described as an infrequent occurrence. Consequently the responsibility was said to remain with the members of the project group, one of whom stated "you know, a lot of it comes from us, we have to have the ideas" (District Nurse 3, Trust 2). A manager concurred with this view, observing that there was a clinical practice review group for each clinical nursing specialty, which met on a regular basis and acted as:

the forum where staff identify their own umm, concerns with regards to the community nursing services and, we address these issues (Manager 3, Trust 2).

There was however a failure on the part of the majority of nurses working in the locality to provide suggestions, with the manager adding that:

It has to be said in all honesty that not many of the initiatives that we've shown have come directly from staff, it usually comes from the small group of people (Manager 3, Trust 2).

The second means of identifying projects was associated with the use of conceptual

frameworks to conduct a diagnostic reading (Morgan, 1986), which provided a means of comparing the requirements of the clinical governance agenda with aspects of community nursing practice. Morgan refers to the use of conceptual framing as the initial stage in analysing practice. This, in the complexity of organisational systems, must commence from a position in which it is recognised that “organizations can be many things at one and the same time” (Morgan, 1986, p. 321). It was apparent that, in selecting these frames, use was made of the available scripts in the organisational context, described by Czarniawska as the “contemporary and historical repertoire of stories, sometimes divided into ‘internal stories’ and ‘external stories’” (2004a, p. 45). However, it was also apparent that in the majority of instances there was a seemingly uncritical reliance on these by the majority of the respondents. Three primary frameworks were drawn upon by the respondents: peer reviewed clinical standards, key tasks in the community role; and the patient pathway. Each of these permitted a different perspective of the agenda and potential areas for action. A fourth approach was also evidenced in one location, drawing upon clinical and managerial precepts.

The first frame of reference was provided by the use of peer reviewed clinical standards and guidelines including those produced by the SIGN and the CSBS. As outlined in Chapter 5, in Trust 1 these were associated with the development of an organisational structure for clinical governance, resulting from the Trust:

committing and, if the clinical governance management group are signing up to specific SIGN guidelines, or umm clinical standards, [...], we need to be very clear that we tie in completely with what the Trust is signed up to (Manager 3, Trust 1).

These standards and guidelines were used by some respondents to provide a basis for developing local nursing standards:

a lot of our standards are devised around SIGN guidelines. So if there's a SIGN guideline on a nursing issue say leg ulcers, wound care, diabetic care, care of the patient with a stroke, care of the patient with a catheter (District Nurse 2, Trust 1).

However, for one manager this approach was causing difficulties due to the volume of material and advisory documents being produced, which resulted in staff receiving “a whole bunch of SIGN guidelines, because there’s lots of enthusiasts that want to publish” (Manager 1, Trust 2). This was associated with a proliferation of clinical effectiveness activities by health professionals, with the manager indicating a need to encourage more focused activity. To achieve this, the manager proposes the adoption of a more questioning approach to the usage of these documents, considering how:

things like umm are guidelines being used? Are they being implemented [...] as part of clinical governance? Or you know is the balance right? Are you using evidence? Do people have the training to be able to umm, to access and use evidence in the clinical assessment process? (Manager 1, Trust 2).

The respondents were also found to draw from other sources of clinical information and guidance current in the health care system, including protocols for patient care published at local and national levels by managers, clinical specialists and expert groups. However, the volume being produced from both recognised and unrecognised sources, combined with problems identifying the credentials and authority of individual documents, was reported by one staff nurse as causing significant difficulties for her. The staff nurse describes the ambiguity of the situation, describing the Trust as “protocol central” and thereafter, whilst recognising the authority of protocols and importance of using EBP, simultaneously recounts the problems that:

they’re coming out from a variety of different, a variety of different areas. I don’t know if I can necessarily pin down exactly and say you know exactly where it came from. Professional developments yes, and clinical services development probably, managers I think as well. It just comes in the internal mail and you just get it [...] it’s not entirely, I wouldn’t say from my perspective it’s particularly clear who’s churning it out and, whether entirely all of it is for action or some of it is for information (Staff Nurse 1, Trust 2).

The nurse also voices a concern that the nursing profession may develop evidence based protocols for all aspects of nursing practice, noting ironically that:

I'd like to think that people wouldn't, they wouldn't think of that. But I've a funny feeling that people will, and say thank God I don't have to think about it, I can follow these rules for everything (Staff Nurse 1, Trust 2).

This concern was to some extent borne out by other respondents who indicated a requirement for evidence based standards and protocols on all aspects of community nursing practice, including bathing patients and oral hygiene. This developing focus on aspects of nursing practice is also related to the second frame of reference identified in the nursing narratives. Rather than drawing from peer reviewed and authoritative statements as a prompt for action, recourse was taken to identifying significant aspects or tasks in community nursing practice. Thus some respondents recounted how nursing practice was divided into a sequence of stages and linked, where possible, with evidence based guidelines to produce standards for clinical audit. This was recounted as having been a problematic process, particularly in relation to a similar exercise conducted for health visiting. In this instance the health visitor standards were based on the care required by two client groups, children and the elderly. However, the account of the development of core standards for community nursing:

was a bit more difficult [...] we started off with something like referrals. Referral times, that a standard referral would be seen within three days. You know a non urgent would be seen within two days, an urgent would be seen the same day, if the referral was received before 3 p.m. You know that that sort of thing, then we worked through documentation and, we worked through various parts of their jobs (Support Nurse, Trust 2).

Thus standards were developed on a number of tasks including admission, discharge, oral hygiene, wound care and referrals. In each case these were supported by the completion of a literature search, supporting references, evidence based statements where applicable and a programme of regular updates; thus seeking to address the problems identified with the short shelf life phenomenon of earlier standard setting

exercises. A total of fifteen core standards were produced for community nursing, forming the basis of a rolling programme of clinical governance for community nurses and an aspect of the performance review process within the locality. A similar focus on core aspects of the community nursing role was also evidenced in the account by one manager who describes the nursing service in a locality as having standards for:

response times and things like that. We have all our standards relating to wound management, to pressure, umm you know to assessments umm for mobility and things. So yes we do have sort of fairly strict standards that we would expect the staff to follow, with their assessment criteria umm, documentation, and things like that. There are standards for that (Manager 2, Trust 1).

These accounts indicated an evident reliance on using task based approaches as a basis for standardising practice. This is an area where concerns have been raised, particularly with regards to the debate surrounding nursing skill mix in the community setting. It is argued that the use of a task based approach fails to capture the actual skills used by district nurses. Furthermore:

simply making skills 'visible' does not in itself provide evidence of the value of the work of district nursing team members or the importance of their skills to patient outcomes (McIntosh, 2000 p. 110).

The third means of framing the clinical governance agenda for community nursing was with reference to the use of patient pathways. A manager explained the purpose of clinical governance by referring to patient pathways and emphasising also a concern with financial matters, "I think what we're trying to do is make the patient journey more complete and more compact and more efficient" (Manager 2, Trust 1). Similarly, another manager notes that using patient pathways as a basis for conceptualising clinical governance in primary care is:

the easiest, a very easy way to actually look at what happens in primary care. And that kind of the journey approach and [...] the sort of stages en route, and saying well you know,

greater choice, raising the performance of hospitals and GPs, and improving the quality of healthcare. These reforms were to be delivered through the introduction of a new form of organisational governance (Klein, 1995), based around the development of an internal market comprising the purchasing organisations of Health Boards, GP Fundholders and the provider organisations of the self-governing NHS Trusts. The underlying logic of these developments was that, through the processes of competing and agreeing contracts for services, the providers would be encouraged to improve the efficiency, effectiveness and quality of the services provided and the purchasers would act in a monitoring capacity (Harrison and Pollitt, 1994; Klein, 1995).

The improvements in the quality of health care were to be delivered by a multi-faceted approach which spanned service provision, organisational management and professional quality; although there was little evidence of co-ordination between the initiatives (Harrison and Pollitt, 1994; Pollitt et al., 1998). The main gauge of service quality was the measurement of service provision against the quality standards that had been agreed by the purchasers and providers. These quality standards were subsequently described as being one dimensional with an undue concentration on factors such as waiting times (Klein, 1995), although the arrangements did serve to formalise management involvement in quality related matters. Secondly, the operation of NHS Trust Boards was subject to quality assurance processes, resultant from the introduction of corporate governance principles (Ferlie et al., 1995; Dunlop, 1998). These best practice principles for the corporate governance of organisations had been established by the Cadbury committee (Dunlop, 1998), following a number of well publicised business failures in the private sector, and provided a code whereby the probity of company management could be assured and controlled. The introduction of these principles to the NHS was intended to guarantee that the operation of NHS Trust boards was based on openness, disclosure of information, integrity and accountability and that the means were in place whereby members of these boards could be held to account (Cadbury, 1992; Ferlie et al., 1995).

can we make this better or do we have to do it this way?
(Manager 1, Trust 1).

A support nurse also found the concept of the patient's journey useful in identifying the key stages of clinical governance activity by placing the patient at the centre of the care system for community nurses:

I'm very much focused on umm on the patient's journey, the clinical outcome measures, improving the service that the patient receives you know at the point of delivery. [...] I think very much my role involves as I say the outcome measures, clinical effectiveness, by trying to get these across to the staff, to remind them that it should be patient centred care (Support Nurse, Trust 2).

This approach provides a means of conceptualising clinical governance which crosses professional and organisational boundaries and, in so doing, integrates clinical governance with clinical processes; a factor also noted by Degeling, Maxwell and Iedema (2004a). The participants however, indicated that the means by which to achieve this had not yet been developed.

A final means of identifying topics for clinical governance indicates an overlap between clinical and managerial audit, with the project described as having both clinical and financial implications. The specific focus of the project was to address the number of call outs by clients for the district nursing evening and night service. The resultant audit identified:

that the majority of their call outs are to do with catheter related problems. We've tried to look at how we can address these problems from an education perspective, patient education perspective (Support Nurse, Trust 2).

Evidence from the audit findings suggested that an appropriate amount of time was spent visiting these clients, thereby providing the manager with the information to argue on the basis of an appropriate resources usage, and:

that actually there wasn't much more we could do and, that the man hours spent you know visiting these people were appropriate for everything you know (Manager 3, Trust 2).

This concern with the financial and clinical considerations was not limited to managerial staff, as was indicated by a district nurse who describes clinical governance in terms of providing evidence:

that we're giving the right quality of care and at a you know an adequate resourcing level, that we're working within the resources that are available (District Nurse 4, Trust 2).

6.1.2 *Assembling the cast*

A significant feature of the descriptions was the acceptance that clinical governance was a collaborative process and that actions were to be conducted through the creation of project groups. In only a few instances were individual nurses identified as undertaking any activities related to this agenda. Even then the examples presented were in terms of preparatory work, as "the sort of groundwork and then [we] got the group together" (District Nurse 2, Trust 2).

This reliance on groups was a recognised means of advancing change and development in the health care setting and, according to one participant, was used whatever the topic in question:

it's no matter what. I mean whether it is sort of audit, or quality assurance, or anything. Or maybe it's something to do with nurses you know the latest thing something like that, there tends to be a project group identified (District Nurse 2, Trust 1).

The accounts indicate that having identified the script, the next consideration was to select the cast who were to address these issues. A number of factors were found to influence this selection, including the reported lack of interest of the nursing majority, resourcing, time constraints and geographical issues related to the widely distributed workforce. As a result, selection of staff seemed to follow from those factors, noted in Chapter 5, of organisational, managerial and personal

considerations. Consequently, many of the groups were reported as being small in number with between three to six members.

There was a reported concern with promoting communication across the nursing teams, to keep other nurses informed, and also as a means of involving them in activities and projects. Thus a district nurse recounts identification of representative members for a project group as being, in part, determined by geographical considerations:

So I was in contact with my area but not so much the other area, so what I did was I had two people from the other side of [the locality], the sort of the west side of [the locality] if you like. And I got three because there are more practices in this our group, umm three people from our group (District Nurse 2, Trust 2).

Amongst other considerations were the knowledge and perceived authority of group members, with a district nurse indicating that some groups were initially formed by calling upon the:

the sort of union reps that are on this. And then what happened is other people are sort of pulled in from the three localities as key people and, then they make another wee working group (District Nurse 2, Trust 1).

However, this was considered an infrequent occurrence, with the other groups reported as representing a mix of nursing grades. Furthermore, members of these groups had the ability to act as conduits between the group and nurses in other locations.

And the six of us all together make up the group, and there is a mixture of G grades and staff nurses on that group. After the meeting I asked for volunteers basically, and then it was a case of phoning up and approaching people and saying would you be interested because. [...] I did have a couple of people, a couple had, had you know seemed quite animated about it and quite interested, so you know I approached them. And it was quite easy to get people together (District Nurse 2, Trust 2).

The nurse also detailed how these group members were persuaded to become involved, indicating her own pivotal role as group leader in driving forward this project. Finally, the issue of the continuity of group members was referred to, with one district nurse noting the personal and professional advantages arising from her ability to move between groups, particularly with reference to:

having put in work in the first instance it was nice to see how the whole thing evolved and, how it was taken forward. There wasn't really a great change of focus, it was really just a case of a continuum you know, and a lot of the work we are going on to do now, actually makes sense of all the initial ground work that had to be done (District Nurse 4, Trust 2).

Similarly, with reference to a short-life working group, a district nurse indicates that her involvement in the completion of a task resulted in the invitation to join a subsequent group:

And then you maybe put forward the guideline that they ask you to do and, [...] because of that they pat you on the back and say you did a good job, how would you like to do this bit? So this is what's happened with this. I'm now on this other group because I helped produce the guidelines from the very start of the service and, now we're trying to get the final ones sorted out (District Nurse 2, Trust 1).

Concerns were voiced related to the disadvantages of drawing from a small pool of nurses. An example was given of a nursing standards project which failed to develop beyond the confines of the group, described in this instance with the group tending:

to be very insular, there's a little group that works on [nursing standards] and then they get lost again (Manager 2, Trust 1).

This comment recalls the observation reported in Chapter 4 related to the potential insularity of groups in the community.

6.2 Enacting and persuading

Having selected a script and cast, the narrative moves on to consider the enactment of the drama. The respondents reported on the use of an array of skills and knowledge, which are considered in terms of two discrete sets of actions. These are the development of formal systems through the use of technical skills to develop standards, audit tools and to conduct analysis. Secondly, there were the interpersonal skills associated with communicative abilities, interpersonal relations, and ability to convince nursing staff on the merit of these new systems. These two forms of action are representative of Bruner's (1986) description of the paradigmatic and narrative modes. The final section considers an alternative view of these proceedings by examining the use of the word "looking", which is used by all respondents as a generic term to describe the enactment of clinical governance.

6.2.1 *Enacting formal systems*

Following the agreement of a topic, the respondents recount how these were enacted. In the majority of instances this involved the development of clinical audit projects, drawing upon skills in preparing standards, designing clinical audit systems and preparing audit tools. Less information was provided by the respondents on the subsequent analysis of the data and presentation of results. Interestingly, some respondents indicated concerns related to the increasing formalism and use of documented processes in health care, or as one nurse notes the:

incessant need to formalise everything that we do and write it down. And I think we have to say well what do we actually have to write down? (District Nurse 3, Trust 1).

The preparation of systems for clinical audit and clinical governance were largely concerned with the development of formal systems, based on a paradigmatic mode (Bruner, 1986) and in particular the use of technical writing skills. This was in some instances underpinned by reference to the formality of a project management approach as was apparently the case with a support nurse who states that:

when someone says I want to do such and such a thing, I get them to give me an overview of what they actually want. And

we discuss it, toss ideas around, work out a work plan and I give them a time frame for this (Support Nurse, Trust 2).

The initial stages of preparing clinical audit systems were described in terms of formulating the topics into standards or measurable criteria, with a support nurse portraying this in terms of a question and answer process with the district nurses:

You need to talk about what you do, you need to tell me about what you do, and from that I will ask questions as you're asking me, and from that I will try and formulate that into some methods or other, that they can use in their practice (Support Nurse, Trust 2).

A similarly discursive, collaborative and reductionist process was outlined by a manager who recounts an exercise that compared the requirements of the clinical governance agenda and current organisational arrangements. The staff were said to have:

shared, we photocopied, we sat, we debated, we discussed, and we broke it down into the simplest elements. You know looking at needs assessment, looking at quality, looking at how you deal with incidents that crop up, whether it be complaints and how do we deal with it. And I think we took it down to the basic levels we possibly could (Manager 3, Trust 1).

Having identified the criteria, these were translated into measurable statements. On occasion writing the standards was reported as a difficult process, with a district nurse providing a detailed account of the problems she had experienced with standard setting exercises, describing these as a "nightmare". The nurse continues by indicating that this situation has improved, although she expressed uncertainty as to whether or not this resulted from her development of the required skills or changes in the management of standard setting systems. Of particular note in the following description is the reference to approval being provided for standards suggesting a confrontational, rather than collaborative, process:

you used to write a standard and you know you had your structure, your outcome. And so many of them were sent up for approval and then they got thrown right back again

because the wording wasn't appropriate. I don't think that's become such an issue now, whether you know the original way of writing standards is somewhat relaxed, or whether it's just that as you mature through your nursing career you appreciate you know, what you're actually trying to do with standard writing (District Nurse 4, Trust 2).

It is clear that communication with other nursing staff remains an important aspect of writing and producing standards. Following from the descriptions of developing representative working groups, the role of these members of staff as a communication channel was detailed. These processes were an integral part of the design and agreement of clinical audit systems. A district nurse explains how she used group members:

to feedback to their practices, that they'd sort of took responsibility for doing that to [staff]. And then feedback to me any information and also it's a point of focus for me. I mean if I'm wanting to get some information out I can phone them and, their job is to maybe you know get that out (District Nurse 2, Trust 2).

The two way flow of information and comments also featured in the final stages of the design processes, with the staff completing draft versions of documents:

and then the drafts have to go out with a time limit on them, saying unless we hear from you [laugh] by then, we will take it that you know these standards are acceptable to you (Manager 2, Trust 2).

There is an implied reference in this comment to difficulties in obtaining the opinions of other nurses, a factor resolved by the imposition of a time limit. Another district nurse also recounts an initial failure to engage staff in these processes, despite inviting them to a discussion on the issues, "and of course one person came, and that was it" (District Nurse 2, Trust 2).

A recurrent feature in these descriptions is the identification of an evidence base for practice, which occupies a dominant place in some respondents' accounts. Various views are presented, from those of nurses who strongly support this approach

through to those who express some concern. Of the former group a staff nurse describes the initial writing of the standards as being followed by:

then we evidence based them. Our core standards hopefully are evidence based practice and are going to tell us exactly you know, how we should be approaching something (Staff Nurse 1, Trust 2).

The standards are therefore perceived to detail “exactly” nursing practice on the issue in question and to derive authority from the use of an evidence base for practice. This respondent also indicated the concerns raised by some nurses related to the impact of formal systems on the clinical judgement of nurses. Despite the exact detail statement noted above, this nurse describes these documents, including protocols, as:

just asking you to focus and say well this is, these are the core things I have to do, and my clinical judgement will augment that (Staff Nurse 1, Trust 2).

A district nurse also notes the authoritative base provided for the standards by stating:

if nothing else these standards and all the tools should all be you know evidence based to the nth degree, you know we’re not just sort of plucking an idea out, no lets try that (District Nurse 4, Trust 2).

Another staff nurse also expresses her level of conviction regarding the use of EBP contrasting this with her concerns related to the “sacred cow issues in nursing” (Staff Nurse 2, Trust 2). Thus, custom and practice procedures are identified as having resulted in the continued use of practices on the basis of “it’s because we’ve always done it that way” (Staff Nurse 2, Trust 2). The nurse continues by owning to:

a bee in my bonnet about some practices that are carried out, that are not possibly well, certainly there’s no possibly about it, [...] they’re not evidence based (Staff Nurse 2, Trust 2).

This is not a viewpoint shared by all the respondents, with one manager commenting on the seemingly uncritical reliance on the use of EBP, further observing that many nurses are only concerned with EBP prior to a job interview, as:

an 'in' thing to say. But of course there's a lot of practice is not research based or evidence based because there isn't evidence out there. So it's really best practice (Manager 3, Trust 2).

A support nurse also depicts EBP as being problematic for some nurses and, based on an erroneous perception of this agenda, as being considered something nurses are not able to understand. This is described as being a consequence of the identification of the evidence-based agenda with the medical profession. As a result some nurses are said to view EBP as:

oh that's something magical. And we don't have a clue about that, and maybe the doctors have got it all sussed, but we as nurses don't have it sussed. I don't think that's true, but I think it seems like something golden and wonderful that's up you know in the sky (Support Nurse, Trust 1).

The next stage of enactment is the production of audit and assessment tools. Only a few respondents detailed the development of an audit tool, with the complexity of this stage apparent from some of the comments. Despite this, one district nurse describes the process with an almost beguiling simplicity and brevity, as involving nurses in devising and seeking:

out tools, obviously assessment tools so that we can then monitor and audit of course, the regular care that's being given (District Nurse 4, Trust 2).

From the respondents' accounts it was apparent that these processes were, on a number of occasions, assisted by the support nurse who describes having "introduced a range of core clinical standards, we've introduced an audit tool, from scratch, worked them up from scratch" (Support Nurse, Trust 2). This resulted from collaboration with the district nurses, with a nurse recounting that if:

they're going to audit something, she'll say to us well what has to be included, [...] and she'll come back with a draft and then we, we go through it and, say well you know you'll have to reword this phrase, or you haven't included this or whatever. Umm, so we do a lot of the work, we carry out the audits mostly, and then she does the work at the end (District Nurse 3, Trust 2).

One manager also acknowledged her reliance on the support nurse to conduct the audit programme, observing that:

I suppose we rely on one another. It's up to me to say to her away you go pay a visit to that area, that area [...] and you know use the agreed audit tool and, give me the results, tell me how the troops are faring (Manager 2, Trust 2).

However, for another group there was significantly less support available with the working group reported as conducting most of the audit themselves. In many instances the actual tasks were completed by the district nurse leading the project, resulting in the report of this as an on-the-job learning process:

I did most of it myself, but well no the first one. Latterly the team used the audit tool and, it was just a question of is this there or is it not, and is this done or is it not? Umm, and it was a case of yes, no answers. So the first one was a case of pulling notes in the [...] locality office, pulling out notes. [...] You know when you start off you only begin to realise the problems that you've created, of the difficulties (District Nurse 2, Trust 2).

A similarly varied picture was presented with regards to the final stages of the audit process of data analysis and presentation of the results. Once again a support nurse was identified as providing a considerable amount of assistance with analysing the data, including use of statistical software and resources provided by the clinical governance support team. A second group were, however, reliant on the skills of group members and additionally their ability to call upon other specialists, known to the group members, on a more ad hoc basis. Consequently, the nurse leading this group commented on both the lack of support and time available to facilitate completion of this project: The nurse also remarked that:

Declaration

I hereby declare that this thesis has been composed by myself and that the research on which it reports is entirely my own work. This thesis has not been submitted, in candidature, for any other degree, postgraduate diploma or professional qualification.

Jane Howell
October 2006

These reforms also saw the first formal arrangements for the measurement of clinical quality with the introduction of systematic medical audit (DoH, 1989; DoH, 1989a), although this development was described as protecting the market from claims of putting profit before quality (Butler, 1994). This initiative was also associated with the development of managerial control over the medical profession due to what was described as, the “logical and even elegant coherence in the white paper’s proposals for tightening the management structure of the service” (Butler, 1994, p. 19). The policy stated that “[e]very consultant should participate in a form of medical audit agreed between management and the profession locally” (DoH, 1989, p. 40), but in practice the involvement of managers in medical audit was minimal. The initiative was subsequently changed to that of clinical audit and extended to include all other health professions.

As a consequence of the 1983-1991 reforms, considerable interest was engendered in quality initiatives with advancement on professional and managerial fronts (Harrison and Pollitt, 1994; Taylor, 1996), and it is against this backdrop that the clinical governance agenda was introduced.

1.1.2 Clinical governance policy framework 1997-2000

The Labour government’s introduction of the clinical governance initiative (Scottish Office, 1997; DoH, 1997) provided the next significant stage in the development of the quality agenda. The initiative formed part of the government’s ‘third way’, building “on what has worked, but discarding what has failed [...]. Instead there will be a ‘third way’ of running the NHS - a system based on partnership and driven by performance” (DoH, 1997, para. 2.1-2.2).

The primary goal of clinical governance was to place quality at the centre of the management agenda, along with finance, by ensuring that quality became an “integral part of the NHS governance framework” (Scottish Office, 1998, para. 3), and that “corporate accountability for clinical performance” was created throughout the NHS (Scottish Office, 1998, p. 2). In furtherance of this, the responsibility for clinical quality was placed on the NHS Trust Chief Executive. Clinical governance

I don't feel that much pressure to finish it as I should. Because it's not my fault because I work full time and, I don't have this day anymore to do it. [...]. Not that I'm blasé about it, I really want to finish it, but I don't worry about somebody coming and saying to me what on earth are you doing with it? [...] I'm quite keen to do it, I'm enthusiastic to do it, but as with everything else it's getting the time (District Nurse 2, Trust 2).

6.2.2 *Persuading others*

The second stage of enacting clinical governance was clustered around accounts concerned with attempting to involve others in the agenda and, accordingly, some respondents exhibited skills in the use of persuasion. It is apparent from the earlier stages of this metanarrative, that the respondents drew upon a range of communicative skills throughout the various stages of their involvement; with the attempt to convince others seemingly inherent in all stages of conducting clinical governance. This perhaps results from a lack of interest on the part of the nursing majority combined with perceived time constraints. Consequently if the work of these groups is to avoid being viewed as nothing more than a paper exercise, there is a requirement that group members seek to involve other staff.

The final stage of these projects was identified by respondents as ensuring that other nursing staff complied with the standards and changed their nursing practice in line with audit results. The scale of this task and the difficulties encountered were presented by some respondents and, in particular, the problems of attempting to involve nurses who are:

quite happy just continuing doing their own thing, and it needs someone to say ah but have you thought about this? And then people will change if they see it's for the good. But when you're getting on with your everyday caseload not thinking about things like that. You're just doing things that you always do (District Nurse 3, Trust 2).

In a few instances persuasion was not such a problem for those respondents with direct managerial responsibility who were used to implementing nursing standards. This was in part due to the managers' membership of a performance review group

and the implementation which followed from the managers' actions. These are illustrated by:

once we decide to do something, once we finish that piece of work, she will then take it to the wider group. Or she will hand it out and say you know the group has decided or I have decided. You know, I've asked the group to do this, this is the finished piece of work and you will now do it (Support Nurse, Trust 2).

In the majority of instances, however, this managerial mechanism was absent and therefore a requirement was placed on the staff to convince their peers of the need to be involved in these developments. The involvement of the nursing majority was, in these cases, presented as a voluntary process and reliant on the persuasive ability of the staff conducting these projects.

Communication and feedback were also represented as being fundamental to these processes and dependent on the provision of information to all organisational levels. Related to this, one respondent cautions that if this process was not completed correctly:

And the right emphasis placed on things, then it's an uphill struggle no matter which way you look at it. Because people will always be frightened of something that they don't already know, and they will always view things in my experience, with suspicion (District Nurse 3, Trust 1).

To convince others of the value of being involved a range of arguments was used, with amongst the most frequently occurring those pitched at the level of the profession and improving performance. Thus a district nurse notes a sequence of steps initially concerned with making staff aware of developments and the perceived authority of an evidence based approach:

I would like to think that in that sense if we can increase the awareness of the development of standards, and actually promote best evidence based practice, and all of these aspects of it, that the end result would be better than it is currently. I'm not saying it's bad, but that you know we would always be seeking to improve (District Nurse 3, Trust 1).

In a contrasting example, another nurse provides an argument focused on a stated concern with “valuing staff and actually getting them to be encouraged and enthused and motivated to do something that’s fundamental to the process” (District Nurse 3, Trust 2). Finally, a manager refers to engaging nurses through a concern with proving that “what we do is value for money” (Manager 2, Trust 2).

From these accounts the call upon the persuasive abilities of staff are apparent and considerable; enacted through a range of arguments which they use with their peers. There is evidence from the participants of the extensive range of arguments which they are called upon to present to their peers. A district nurse specifically refers to this aspect of the role as:

It’s like anything else it’s trying to get people who are interested to sort of be agents, to encourage the other people along with them. I think probably not making it terribly high brow, just bringing it to meetings like the district nurse meeting, getting a bit of ownership you know (District Nurse 4, Trust 2).

Whilst another district nurse recounts the problems and demands she has faced in getting other community nurses to:

accept something and you know bending over backwards to explain things to people, to make it seem simple. And you know point out to them there is no extra work involved (District Nurse 2, Trust 2).

6.2.3 *Enacting or looking*

Although the respondents reported in some detail on the stages of enacting clinical governance, there was also in their accounts considerable reference to the term “looking”. As was indicated in chapter 5 the most commonly used term was “standard”, however analysis of the narrative revealed “looking” as appearing only slightly less often and, on occasion, the two words were combined as in the phrase “looking at standards” (Manager, 3, Trust 1). This section provides a brief overview of those instances when respondents described the enacting of clinical governance in terms of “looking” and “look”.

The frequent use of this term gives rise to the question as to why “looking” was used with such regularity throughout these accounts, spanning all of the contexts, themes and settings with which the clinical governance agenda was concerned. There is a deceptive simplicity in this term, suggesting varied meanings including the colloquial use of “seeing with your own eyes” to indicate a dismissive attitude, a level of action or implied inaction, or perhaps to reveal an accepted convention of use with reference to clinical audit and clinical governance, and finally, as a simple short-hand for expressing a complicated series of processes concerned with involvement in clinical governance.

A manager provides one of the most comprehensive examples in which “looking” is used to signify the stages and processes associated with clinical governance, defined in terms of:

looking at standards, it's looking at, not only I suppose within the Trust, but looking at standards that are imposed from outwith umm involving everybody. Looking at how we deliver services, and I suppose redesign comes on from clinical governance, looking at how we can redesign. Umm, looking at the engagement of people to develop the service and to tolerate the standards that we would be setting. And the monitoring of the standards, the training of the staff to maintain it (Manager 2, Trust 1).

In this quotation “looking” is applied to standards, redesign, delivery of services and the staff group. Alternatively a district nurse applies “looking” to the nursing profession, indicating that this has become an object of study with standards and auditing used to “look” at nursing itself and how it can be improved, is really the way I look at it” (District Nurse 3, Trust 2). The objectification suggested by this statement is similar to that proposed by Power (1997), in which organisational systems and management processes have become objects of interest for audit processes. A manager also includes the patient pathway in this process by describing it as a “good way” of conducting audit and:

looking at the patient's journey. I have to say that's probably a good way, [...] particularly because that's been certainly

A final example of the extensive usage is that of “looking at auditing” which, in the light of the analyses by Roberts (1991) and Power (1997), is a seemingly tautological statement. From this line of development, auditing and accountancy systems are found to be related to the creation of centres of calculation, lines of visibility and transparency (Roberts, 1996; Power, 1997). This bears some similarity to Potter’s (1996) examination of the use of visual metaphors, which located their usage in the development of the scientific method. The results of this analysis can be applied to the use of the term “looking”. In this study Potter examined the roots of phrases which contain references to visual imagery, including those of “*looking* for the truth, *seeing* the point, *viewing* it as self evident” (Potter, 1996, p.20). The roots of these phrases were traced to the initial development of scientific experiments and, from this, Potter proposed a relationship as existing between the use of these phrases and the techniques of scientific observation and measurement of empirical reality. It is therefore proposed that the seemingly mundane usage of “seeing”, “looking” and “viewing” is replaced with a version indicating that the understanding of an object is based on an implicit empiricism. Finally, there is an alternative use of visual imagery current within the literature associated with accountancy and governmentality. These were found to draw from Foucault’s concept (1977) of the disciplinary society, and also the application of this thesis in Rose and Miller’s (1992) governmentality theory.

6.3 What was the point?

Every art and every inquiry, and likewise every act and purpose, is thought to aim at some good; hence the good has rightly been called that at which all things aim (Aristotle in Burke, 1969, p. 293).

The enacting of a story or drama is, according to Burke (1969), described in terms of achieving a purpose or good. Therefore, this final section considers the purposes or goods identified by the respondents as a result of involvement in the clinical governance agenda. Some of these have already featured in the accounts provided in

section 6.6.2, related to persuading other staff to engage with the clinical governance agenda. This factor provides an example of the ambiguity mentioned by Burke as occurring between the elements of the pentad, thus factors which appear to fall under purpose are also relevant as part of the agency of individual actors.

This final section of the narrative examines those goods resultant from the clinical governance agenda and which were identified by a majority of the respondents. These are presented under the headings of standardisation of nursing practice and risk management, promoting sharing and learning, and finally, the development of a nursing voice. A feature of these perceived benefits is, in many cases, their relative intangibility and reference to ideal situations which are only infrequently enacted within the clinical governance agenda. The exception to this is the standardisation theme which refers directly to the development of core nursing standards.

6.3.1 Standardising nursing and managing risk

The standardisation of nursing practice forms a recurrent theme in respondents' accounts, particularly those presented by the managers, with standardisation related to the development of clinical governance systems which encompass all aspects of health care. This is described as a "coming together of everything that contributes to the quality of patient care" (Manager 1, Trust 2).

Amongst the aspects of community nursing which were related to improving quality, a manager stressed the importance of ensuring that "we're all doing the same thing" (Manager 3, Trust 1), adding also that advantages would arise from staff being able to move freely between different GP practices:

So that if nurses move around from one practice to another, they all know exactly what protocols there are in place to follow (Manager 3, Trust 1).

In a similar vein, another manager details the systems which are required to be in place to promote standardised practice. These include information and an evidence base for nursing practice, resultant from which all nurses will adhere to the same protocols. The manager justifies this by stating that nurses:

need something that they can all follow and all be adhering to evidence, using the same evidence based practice you know across the area. On wound management, on you know, [...] how do you admit and discharge and admissions, you know first referrals, what are the criteria, what should you be asking, are we all asking the same things? (Manager 2, Trust 2).

Interestingly, nurses also indicated the advantages which would arise from the standardisation of nursing practice. In particular, a staff nurse expressed the view that standards should be used to rectify those areas where practice has become “ad hoc”, adding that this situation is dependant on the nurse attending the patient. Thus the nurse states:

I think it's actually better that we've got recognised structures to work to you know in a way. Whereas before it was all a wee bit you know 'easy osey', a bit kind of ad hoc, and varied very much from district nurse to district nurse (District Nurse 4, Trust 2).

However, an interesting point is raised by a district nurse who notes that whilst she prefers not to follow the recommended approach for assessing clients preferring instead to use a conversational approach, she still perceives there to be advantages in the use of standardised methods as a means of teaching junior nursing staff. This nurse also indicated the particular relevance of using protocols due to the changing skill mix in the community. Therefore the nurse describes how:

when I'm assessing a patient I just go in and it's like a conversation, and I have specific things that I want to find out, and I'll try and get the conversation to go round to that point. [...] Umm now for a new staff nurse how do you teach them that it's quite difficult? [...] It's quite difficult for them so [...] it's quite good to have some sort of protocol or checklist. Because it's helping them get used to doing this, but it's also safeguarding the patient (District Nurse 2, Trust 2).

Associated with this issue is the management of risk which almost appears as a subplot of standardising care. For one nurse, the development of standards is underpinned by an assertion that standards will deliver a wide range of

improvements in the delivery of patient care and a reduction in the risks associated with nursing clients. Clinical governance is described as:

to do with risk management as well and reducing risk to clients, to staff [...] in the Trust, and reducing risk of litigation. And so that's a huge bit and they need concrete proof, they can't just say oh yes, [...] what we're all doing is of a high standard (District Nurse 2, Trust 2).

The reduction in the risk of litigation is also associated by the respondents with the development of clinical governance systems, which are said to be:

making nurses' jobs easier and safer and at the end of the day, making patient care safer, and reducing the risk that people are gonna make mistakes. [...] I think that if you've got a nurse who's going in and confident and, knows exactly what she's doing, then there's less risk to patients. Then that's, that's an improvement as far as the patient's concerned (District Nurse 3, Trust 2).

Thus risk management is described by some respondents as imbuing the delivery of nursing care from the initial assessment through each interim assessment. The nurse operates within a risk management process that promotes nurses to look at their "patient and what's the safest way umm for you delivering the care to your patient" (Manager 3, Trust 1). This aspect of risk management is of particular concern to a district nurse who indicates the processes whereby the nurses in her team assess risks:

and obviously everything we do we have to risk assess and, that's again the district nurses' responsibility. So the nurses have to be involved in that to see where their role is and, then they know that what they're doing is going according to guidelines and you know it's sort of safe practice if you like (District Nurse 1, Trust 1).

Finally, a staff nurse notes that the processes of risk management are linked with research, stating that nursing practice should be underpinned by evidence, as:

you've got to have something, some experience of something you know to say, you can't do this because this isn't going to

work. It's not going to be enough; you've got to have some grounds, [...] quite firm based knowledge or expertise to be able to take something like that on. And the only way you can get that is through auditing and knowing where the problems are (Staff Nurse 1, Trust 1).

6.3.2 *Learning and Sharing*

The respondents identify the ability to share instances of clinical practice and learn from this process, as amongst the perceived benefits resulting from the introduction of clinical governance. However, despite this perception, achieving this in practice appears difficult with many of the comments related to this issue pitched at the level of an ideal, dependent on the actions of individuals and informal processes and arrangements. One exception to this is given in the accounts, although this description of the development of a formal process also indicates the problems with what is an open-ended and non-specific agenda. Consequently, the respondents provide few statements indicating that these desired goods have been achieved. The connection between clinical governance and individual learning is related by one respondent to the provision of time for staff to reflect. This it is stated is:

good for nursing, to give you time out to reflect on your practice and obviously then that improves. Hopefully you'll be able to identify ways of improving your practice, or you know identifying learning outcomes (Manager 4, Trust 2).

Similarly, another nurse also makes reference to the ability to reflect on her practice, with this statement calling to mind Schön's (1983, 1987) concept of the reflective practitioner, for whom practice provides a basis for a reflective learning processes. From this it is also suggested that change and improvements will result from staff being challenged:

to think about what they're doing and to think about their practice, to be reflective in their practice, to think how things can be changed. And why things should be changed, [...] there's no point changing for the sake of changing there has to be a rationale behind it. So clinical governance should you know, it should have a positive impact (Manager 3, Trust 2).

However, a feature of these descriptions is a lack of clarity and failure to detail how this learning and sharing is to be achieved. One manager indicates that a forum is provided by the various groups within the health care system. Thus groups are perceived to enable the dissemination of “good things” and in particular the:

sharing of good practice from one group to the next. And going along and being part of each of the groups, and seeing how some groups do it. Some are working quite differently from others, but sharing the good things from one to the other and vice versa. Or not allowing people to make the same mistakes and, saying that’s been done before (Manager 1, Trust 1).

As with the use of the term “learning”, “sharing” also appears to be an ideal, desirable and unexplained in the respondents’ accounts. The term also features in the clinical governance literature with Swage (2000) in particular presenting it as an integral part of the clinical governance process, seemingly as part of an organisational culture which is comparatively unthreatening. In this, sharing results from the clinical governance agenda and the opportunities which are provided for:

clinicians to take the lead in the delivery of health care, to demonstrate how that can be done effectively, to learn from each other and to share best practice (Swage, 2000, p. 7).

The references to sharing by the respondents in this study exhibit similar characteristics and are associated with staff being enabled to share examples of good practice, across organisational and professional boundaries. Thus the ‘good’ of sharing appears also to be non-hierarchical. However, little information is provided on how this is to be enacted through the clinical governance agenda, with the responsibility instead appearing to be placed on the staff members to facilitate this aspect of the agenda, as:

all these things fit under clinical governance but in a very informal way. But it enhances the standards and it’s a learning opportunity and, you look at how you might have done things differently (Manager 2, Trust 1).

activities were to be an “integral and integrated part of the mainstream business of the Trust” (Scottish Office, 1998, para. 18) with all staff involved in quality related activities. The expressed intention was to develop a “framework for extending this more systematically into the local clinical community, and ensure the internal ‘clinical governance’ of the Trust” (Scottish Office, 1997, para. 68) by building on the existing systems for professional self-regulation and principles of corporate governance. Through this framework organisations were to be:

accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (DoH, 1998, para. 3.2).

The initiative was intended to be the linchpin of the government’s quality strategy (DoH, 1998) and advisory documents were subsequently published detailing how the initiative was to be progressed (Scottish Office, 1998; DoH, 1998; Scottish Executive, 2000). A striking feature of the clinical governance initiative was the intention that all staff and organisations, across all sectors of the NHS, were to be included in the developments. At organisational level, the primary focus was on developing the systems and structures to ensure that the Chief Executive was able to meet her new responsibility for clinical quality (Scottish Office, 1998), although in practice this responsibility was frequently delegated to the Medical and Nursing Directors. In support of these responsibilities each NHS organisation was to create a clinical governance infrastructure comprising a formal standing committee, chaired by an executive director of the Trust (Freeman et al., 1999), with responsibility for overseeing and reporting on clinical governance activities to the Trust Board. Formal arrangements were also put in place for reporting upward to the NHS Executive on an annual basis.

A subsequent publication detailed staff involvement, outlining four levels of responsibility: the overseeing role of the clinical governance committee; the delivering role of management; the supporting role of specialist staff; and finally, the practising role of the majority of staff (Scottish Executive, 2000). In practical terms the clinical governance agenda engaged with professional practice through staff

Significantly, even in those instances where a nursing system has been developed to promote sharing and the exchange of exemplars of good practice, there are evident problems with formalising these processes. The system is presented in this instance as having developed in an ad hoc fashion and with the goals underpinning this “sharing” apparently unformed and left to the respondents to agree. This uncertainty is also seen to extend to the identification of those exemplars of good practice which are to be shared. Thus the nurse recalls how she has:

tried to collect areas of good practice from all the health centres. I mean we've got a little list of, I suppose it's good practice. But [...] how do we know it's good practice I don't know? But we have this list of good practice people can share. But if anybody you know, if anybody wanted to know more about it then you know, presumably they could come to me and, I could go to the health centre and we could get that information for them. So we could sort of, in theory try and disseminate good practice (District Nurse 4, Trust 1).

6.3.3 *Promoting the nursing voice*

The final story line is concerned with developing and promoting the nursing voice within the clinical governance agenda and the health care organisation. These statements present a number of recurrent themes associated with the inability of nurses to be involved in developments, exclusion from management processes, and failing to articulate the nursing position and role. This section begins by recounting those problems which are perceived to be blocking the nursing voice and involvement, concluding with the “goods” which would arise from nurses being heard within the wider organisational context.

For one manager the problems with the nursing position are related back to the processes of change and development in the health care sector, resulting in the nursing profession being described as:

a wee bit vulnerable just now all of the changes that have happened over the last few years. You know nursing's not held in very high regard and hasn't been you know for a long time. That's the feeling we get. And obviously its important to identify those that you know are kind of willing to put their

money where their mouth is, and try and do a bit of work that will evidence you know how important nursing is (Manager 2, Trust 2).

Consequently, the manager indicates the importance of nurses speaking up for themselves, although this would appear to be an individual response rather than that presenting a nursing consensus. Similarly, a support nurse also indicates the inability of the nursing profession to be heard and proposes that nurses find a means of demonstrating the unique features of the nursing contribution by bringing:

forth that message about why nursing's important and what is unique about nursing. And what the art of nursing is, because I think the reason why nobody acknowledges it or realises there is an art to it and all that sort of thing, is because we're powerless and we don't, nobody hears our voice (Support Nurse, Trust 1).

These initial comments were lacking in detail as to why the nursing profession was perceived to be powerless, although in other comments this was traced to the fact that many of the nurses involved in the developments did not hold management positions. This was summarised by a manager who observed the complexity for some nurses who are enthusiastic and participating in these developments and through which they are able to identify problems and propose solutions. However, the difficulty is described as arising due to their position outwith the line management structure:

they are not in line management, so I think if they go up to [manager] and say this needs to happen and she doesn't want it to happen, then there's a kind of conflict about how, how it should be implemented (Manager 4, Trust 2).

The ability of staff to enact clinical governance is also perceived to be hindered by the development of an organisational structure which is perceived to limit further the ability of staff to be involved:

From the staff is they would like to be more involved, they're feeling it's being too directed and, they'd want to have more say on what the issues are. So somehow we need to get that balance back again, which they would have felt in the early days of clinical governance, they were the main issues they

wanted to put on the table. [...] So I think we need to look at what's going on between what our agenda is in the clinical governance group and, what other people's agenda is (Manager 1, Trust 1).

These are interesting comments, particularly in respect of the clinical governance agenda being portrayed as requiring collaboration across grades and health care professions. The theme is also mirrored by a district nurse, who refers to the influence of the organisational hierarchy in preventing the voice of practitioners from being heard:

there's a lot of talk down and not enough of what people at the bottom actually say. What would be the advantage of doing something? How would it improve practice? (District Nurse 3, Trust 1).

However one manager, whilst indicating that there are problems with communication, identified part of the problem as being with nurses having difficulties in articulating what they do:

we're not good at articulating what we do. We're good at saying we're busy, but we don't say what we're busy about. So umm and it's trying to get people to think about the quality of the work they're doing, rather than the quantity (Manager 4, Trust 2).

Despite this apparent failure by nurses to articulate their role, a number of goods are nevertheless identified as arising from the involvement of nurses, based on their adaptability, communicative skills and desire to improve practice:

I think nurses have a great deal to offer. I think they are very adaptable, I think they are very skilled, I think they have good communication skills, I think they are able to negotiate and you know kind of see the bigger picture given the opportunity to do so (District Nurse 3, Trust 1).

This nurse also indicates the advantages for the development of the clinical governance agenda which would arise from involving nurses:

I think that would [...] would probably improve the chance of success if they involved people at all levels and, not just considered that those at the higher part of the organisation are the ones with the opinions that matter. I think people much further down have opinions that really matter, that need to be heard (District Nurse 3, Trust 1).

Two-way communication is identified as a significant aspect of this process:

I think trying to engage them in a two way dialogue is more important than sending down a bit of paper and, expecting them to read it (District Nurse 3, Trust 1).

Furthermore, a manager explains the reasons that should direct the involvement of the nurses, including their knowledge of the clinical area and the fact that many are motivated to contribute their opinions:

we know best I think about our service and, therefore we want to try and contribute to any change that might be coming up. Contribute our opinion, and our experience, and our expertise. I feel quite passionately about that. That we need to be saying that that will not work because, or this will be very useful because (Manager 4, Trust 2).

6.4 Summary

To summarise, this chapter presented the participants' accounts related to the enactment of clinical governance and the goods which were expected to arise from involvement in this agenda. This enactment was found to comprise a complex series of stages, involving the development of a script, performance of a range of activities and finally, the attempt to persuade others of the benefits to be obtained from the clinical governance programme.

The study demonstrated the involvement of small groups of nurses in the construction of the clinical governance account for community nursing. On most occasions the script was presented in terms of a standard setting or clinical audit project. These project groups whilst seeming to undertake a breadth of tasks were nevertheless depicted as small, with the development of the agenda seemingly associated with achieving the maximum return from a small investment of staff

numbers. In likening the processes of clinical governance to a drama, this was found to represent the critical stages of the processes involved. Significantly, this image was also successful in capturing the emphasis placed on persuading others, in the nursing community, of the account which was being developed and of the demands that convincing others placed on the staff in these project groups.

Whilst only a small number of staff was demonstrated as being directly involved in the enactment of this agenda, the attention to the representation of other nursing staff through these groups was apparent. This factor was found to be necessary in order to move the clinical governance processes above that of a paper exercise and to promote the involvement of the majority of the staff.

Persuasion can perhaps be conceived of as underpinning all stages of developing the account, from the use of recognised systems through to a concern with formal documented processes. The means of enactment were considered under two headings. First, the development of formal audit and standard setting systems, with these processes likened to Bruner's (1986) description of the paradigmatic or logico-scientific mode. The second form of enactment was associated with Bruner's (1986) narrative mode and concerned with involving others, which was found to place considerable demands on the group members as they sought to promote the involvement of other nurses in the stages of project development and implementation. However the scale of the agenda, small group of staff and number of nurses in the locality setting, inevitably limited the involvement of others within the nursing community. This was in some instances ameliorated by the role of managers and support nurses although there was an apparent lottery associated with the availability of this resource.

The chapter also considered the identification of topics from which the nursing account and clinical governance activity was to be designed. The use of both problem solving and framing devices was demonstrated, with both approaches overlapping on occasion. Amongst processes of topic identification the factors of note were an apparent lack of critical analysis and an absence of a nursing model.

Thus there was an apparent reliance on those stories which were current in the organisational setting to construct the account, including a task based approach and reliance on external standards. These choices were possibly also related to the ability to persuade other staff of the requirement to use resultant standards and audit tools; a factor potentially dependent on the perceived authority and relevance of these topics for the nursing community. This view was substantiated by the apparent dependence on evidence based protocols and guidelines throughout this metanarrative.

In the final section, the theme of persuasion was linked with the various benefits which were identified as underpinning the involvement of the nurses in these developments. These included the unarguable benefits arising from the sharing and learning which some respondents saw as a goal of the agenda. Whilst the discussion related to this was vague, it provided an instance when clinical governance was considered by the respondents as outwith the confines of the community nursing group. Thus information and exemplars of good practice were to be available across professional and organisational boundaries. Other benefits identified were those accruing from sharing and learning, although these were described as vague and intangible goods, which in the context of health care resonated with unarguable benefits arising from the sharing of exemplars of good practice. Benefits were associated with the standardisation of nursing practice and management of risk, with the latter of particular note to the community nurses frequently working alone.

Finally, the difficulties of promoting the nursing voice in developments were considered, primarily in terms of the problems associated with being heard by the senior management within the Trust. The chapter concluded with the benefits which would potentially result from this nursing voice being heard.

Chapter 7

Discussion and further research

[m]an is capable of producing a world that he then experiences as something other than a human product (Berger and Luckmann, 1967, p. 78).

This chapter discusses the findings of the study bringing them together with the literature on clinical governance and theoretical frameworks on accountability. This enables consideration of how nurses construct an account from technologies which seem other than a nursing product. The aim of this chapter is to draw conclusions for management and community nurses, concerning the involvement of the nurses in the agenda and, in particular, with the development of a corporate account for this nursing service.

In Chapter 1 the literature demonstrated both the development of the quality agenda in health care and the contested nature of the concept of quality. Whilst the nursing profession was identified as having considerable involvement with these reforms (Harrison and Pollitt, 1994), this issue received little attention in research studies. To date the concept of quality in health care has remained largely under researched, although some research has been conducted on the management reforms demonstrating the impact on the health professions, notably the medical profession. Much of this focuses on the senior management tier of the organisations, although there are some notable exceptions, in particular Traynor's (1996, 1999) examination of community nurses and managers following NHS management reforms. Although conveying an account of the apparent dualism between these roles, it is argued here that Traynor's study, in presenting an impression of a division between these staff groups, failed to reflect the narratives used by the community nurses and the managers.

A central feature of the clinical governance agenda is the concept of accountability and Chapter 2 considered the theoretical perspectives in this field, identifying the contingent and complex nature of the concept. To capture the processes involved in the construction of accounts related to this initiative a narrative approach, in

particular, that of enacted narratives was selected to focus on the performative nature of nursing involvement in this agenda.

This study contributes to the field of research investigating the involvement of community nurses in clinical governance. It further enhances understanding by considering the involvement of the wider community nursing team in the management reforms and provides a more diverse view of that involvement. A multi-faceted picture of these developments is presented to assist the nursing community in understanding the complexity of the clinical governance agenda and the processes involved in developing a corporate account for community nursing. The study involved capturing the participation of actors across a community setting, including community nurses, managers and support nurses, through the narrative accounts they provided. The contingent and complex nature of these developments was demonstrated through the examination of the stories and traditions the respondents drew upon to construct and reconstruct their accounts (MacIntyre, 1988, Czarniawska, 1997, Bevir and Rhodes, 2003). In so doing, the study recognises the agency of those members of staff, including the community nursing group and middle managers, as an interpretive community concerned with enacting the developments. Thus, this research recognises the effects of the organisational context on individuals and groups. Furthermore, it enhances the understanding of the interactions between community nurses and managers.

This chapter begins with an overview of the findings of this study, which were presented by the respondents through a number of interlinked narratives. It then describes staff involvement in the agenda, questioning the role of 'the others' in these processes and the seeming marginalisation of various groups of staff arising from aspects of these developments. The primary means of developing a community account was found to utilise the unarguable rationalities identified by Traynor (1999), with an emphasis on persuasive techniques and the concurrent discounting of the nursing history and activities in earlier quality related projects.

Finally, consideration is given to the implications of these findings for community nursing and management, nurse education and further research. The research illustrates the ambiguity and contradictions surrounding the development of clinical governance in the community setting. The reliance on managerial and calculative technologies in a context of ambivalence and change must be questioned, in particular, whether or not this will provide staff with the skills: firstly, to respond to the very contested and contingent context they depicted so convincingly; or secondly, to participate in subsequent agendas which may require more than just an ability to control. Other voices are apparent in the respondents' accounts, indicating a concern with sharing and learning. Indeed the study demonstrates the high level of interpretive skills being acquired, albeit applied to the narrow frame of audit processes and technologies.

It is proposed that, rather than rely on systems for clinical governance built on a technocracy, awareness of contradictions and ambiguities in the organisational setting should be used to develop the nursing voice, combined with critical skills to recognise and respond to these very ambiguities. In furtherance of this, an approach is proposed which builds on polyphony enabling staff to lend their voices to how clinical governance systems are being constituted and their role in these developments. This follows from Burke (1969) and MacIntyre (1988), with the purpose being to enable the nursing profession to build on their already evident voice within health care and to engage in debating the contradictions between developing organisational systems and delivering patient care. Perhaps in this way the collaboration required for the development of clinical governance, rather than medical, managerial or other professional governances, will become a possibility.

7.1 Overview of findings

The reported decline in global metanarratives (Lyotard, trans. 1984) has, ironically, resulted in increasing attention on the narratives of agents within organisations. This seeks to understand the agency and interventions of individuals and groups in structuring organisational contexts and the reciprocal processes whereby the understanding and roles of these agents are, in their turn, constructed. For this study,

the use of an enacted narrative approach was concerned with identifying the involvement of respondents in the agenda and how this is explained. This process is also built on the narratives extant within the surrounding organisation and nursing profession. Exploration of these involves the creation of a metanarrative from the respondents' accounts, which has been presented in the respondents' own words in Chapters 4 through 6, the findings of which are summarised in the following section. Llewellyn (1999) describes this narrative as a:

metastory as it depicts the interview quotes from a certain perspective, embedding them in the theoretical stance of the paper and/or relating them to strategic intent (Llewellyn, 1999, p. 228).

The development of a metanarrative provides the grounds for a line of reasoning, built from the reading and interpretation of the accounts. Bevir and Rhodes (2003) explain the processes involved as the unpacking of individual narratives and their explanation, the "elision of alternative narrative and metanarrative cannot be avoided because it follows from telling stories about other people's stories" (2003, p. 5).

Therefore the metanarrative in this study presented a construction of respondents' involvement in this agenda and, in particular, considered how the respondents made and remade their interpretations. This included a view of the means used to narrate how the respondents coped with the inevitable ambiguities and contradictions involved with the implementation of the agenda, within the organisational context. Specific themes of interest to this study were the recurrent narrative of changing contexts and the new technocracy, persuasion and the discounted profession.

7.1.1 Changing contexts and the new technocracy

Change was presented by all the respondents as the new normality; an all pervasive aspect of the organisational context; and impacting on all aspects of the community nursing role. Interestingly, the same instability and uncertainty also featured in the definitions of clinical governance, which was found also to share the same imperative characteristics. Whilst change has featured in numerous management texts as an object of attention both to be promoted and managed (Kanter, 1984;

involvement with various projects and initiatives. Many of these projects had been put in place by earlier reforms and included clinical audit, EBP, research and development, risk management, management of complaints and training and development. An evident goal of the clinical governance developments was to integrate these disparate activities with the corporate business of the organisation (Scottish Office, 1998).

The final layer of this ambitious project was the creation of a national tier of organisations, charged with specific responsibilities for setting and monitoring evidence based standards and guidelines for clinical practice. In Scotland these duties were undertaken by the Clinical Standards Board for Scotland (CSBS), supported by Clinical and Resource Audit Group (CRAG) and Scottish Intercollegiate Guidelines Network (SIGN). In the English and Welsh NHS, these roles were undertaken by the National Institute for Clinical Excellence (NICE) and Commission for Health Improvement (CHI).

Finally, although it was stated that the implementation of clinical governance systems would not replace professional self-regulation (Scottish Office, 1998), the reforms required the development of stronger mechanisms of professional self-regulation through the regulatory bodies of the health professions. Accordingly, whilst professional self-regulation enabled the health professions to set their standards of professional practice, conduct and discipline, the stated expectation of the government was that this freedom must be justified by the professions being “openly accountable for the standards they set and the way these are enforced” (DoH, 1998, para. 3.43).

This policy overview has illustrated the scale and complexity of the management reforms and clinical governance agenda. The following section considers the management reforms and community nursing.

Burnes, 1992), for the respondents, change provided the messy and contingent backdrop within which they worked. The context apparent in these accounts, whilst providing a scene or setting for the drama, was also used to provide a foundation for the explanations. Amongst the numerous changes identified and described by respondents were those promoted by political initiatives and reforms. In the majority of instances these were described in terms which, whilst lacking in detail, demonstrated for the respondents the imperative nature of developments which had to be responded to by the nursing team and managers. Subsequently the compelling narrative of change was found to impact on all aspects of the community nursing role, including that of district nurses who were described as being required to fulfil both a managerial and administrative function. Finally, the change scenario also involved the patient group, whose dependency placed increasing physical and mental demands on members of the nursing team.

Against this backdrop the clinical governance agenda was introduced as the latest in the sequence of government led management reforms of the NHS. The initiative was found to be difficult to describe, with recourse to a range of metaphors by some respondents, including that of an umbrella which was used by one manager to depict the development of an overarching organisational system for clinical governance. The respondents identified the goal of the agenda with quality improvement and a breadth of quality dimensions. Thus clinical governance resembled the organisational context, with changing goals, definitions and boundaries. An interesting omission from the majority of the narratives was the concept of accountability. Despite the centrality of the term in the policy documents, only one respondent described the initiative in terms of both corporate and professional accountability. However, a number of respondents provided accounts of professional accountability indicating that, for them, clinical governance was an adjunct to this professional requirement.

A final and recurrent theme used to present the setting was the descriptions of and positions accorded to 'the others', the members of the wider community nursing team. The respondents made frequent recourse to descriptions of the nursing staff with whom they worked, although there was a considerable degree of ambiguity

evident. Firstly, 'the others' were described in terms which indicated their position outwith these developments and consequently the problems posed by these members of staff to the implementation process. Thus they were described as afraid, not interested, disengaged and lacking the time to be involved in clinical governance. However on occasion, as Czarniawska (1997) indicated, 'the others' were sometimes also 'us', with these positions being interchangeable, as the voice of the nursing majority was evidently one which on occasion the respondents concurred. In this reading, the voice of 'the others' has become a narrative device within the enactment process and used to explain the actions of the participants. 'The others' were also found to be marginalised from many activities albeit, apparently with every attempt made to involve them through audit and clinical governance processes.

The context was presented as an unstable environment and one in which the nursing profession have little choice but to react to developments, with little control over managerial decisions in the organisation. Consequently, some nurses indicated that the job they were currently doing was not the one they had entered the nursing profession to do. A strong impression was given of the invisible hand of God, the *deus ex machina* of Greek tragedy, off stage and moving events along.

As a potential consequence of these changes, the agenda in the majority of instances was seen as being enacted through a cluster of systems including those of standard setting, clinical audit and organisational accreditation. The development of the community nursing account was found to be based on the skills represented by Bruner's (1986) paradigmatic mode of cognition, in which formal systems of description, explanation and categorisation are used. The respondents portray clinical audit projects as being developed in line with key tasks or incidents. A number of staff also indicated their belief that protocols or standards should be produced on most aspects of nursing practice. The evident reliance on EBP and SIGN guidelines, used in many cases as the basis for the development of local standards, protocols and audit systems, was associated by some respondents with the development of organisational systems for clinical governance within the locality and Trusts and with the reporting of the corporate account for community nursing.

In the descriptions of these systems however, the respondents also noted the problems that staff encountered with developing the required skills to participate. Indeed the training and development requirements of this agenda provided a recurrent theme, with a contrast apparent between those participants who had learnt on the job, an unofficial apprenticeship, and the staff nurses who had the required research based skills and were conversant in the use of information technology. Whilst the staff nurses, in particular, were found to support the increasing use of EBP and clinical audit. Some other respondents voiced concerns related to the development of systems based approaches as increasing the use of formally documented processes, with one manager evocatively conveying the thought of some staff “churning out” (Manager, 2, Trust 2) these documents.

A finding of this study was that, despite managerial descriptions of the overarching systems for clinical governance, the actuality presented was less well founded. Thus the apparent edifice for clinical governance across both organisations relied on the work of small groups of nurses dispersed throughout the locality or organisation. These groups met infrequently and in some instances were poorly supported in terms of access to staff with relevant skills and resources. This suggested an imbalance between the intentions of the managers and respondents, and the actions achieved. A further related narrative presented by the participants was of persuasion and the discounted profession.

7.1.2 Persuasion and the discounted profession

Change was presented as the new normality and, moreover, one with which the nurses had to cope. Many of the nurses also indicated problems associated with changes in their role, but despite this they were found to present themselves in the majority of cases, as voluntarily involved in clinical governance activities. A number of respondents also indicated that they personally had a history of engagement with similar projects. There were the inevitable exceptions to this, with some nurses reporting their involvement on the basis of the instruction of their manager. The majority of respondents indicated that they were interested and committed to promoting change and improvements in the community nursing setting. Thus they

displayed characteristics similar to that of the innovators and early adapters associated with change projects as identified by Rogers (1983), with interest identified as the primary determinant for their involvement rather than knowledge and skills. Notably, some managers also indicated there was a requirement arising from this agenda and other similar initiatives for the nurses to develop skills in critical analysis.

A striking feature of the narrative was, however, the considerable amount of time and planning involved in persuading the members of the nursing majority to participate in clinical governance programmes. The processes of enacting were therefore found to have a strongly performative aspect, with an evident requirement to persuade these 'others' to participate. The small size of these project groups, and the previously described recalcitrant attitudes of the nursing majority, necessitated the respondents to use a range of interpersonal skills to encourage other staff to become involved. The narratives also included frequent use of rhetorical questions and answers during the interviews, almost in response to the perceived position of 'the others'. This process was also reflected in the frequent recourse to the advantages of the agenda for the nursing profession and patients, in terms of quality of care. Interestingly, arguments were also provided by all staff grades highlighting the benefits in terms of value for money, concrete proof and achieving a determined level of care; all representing a managerial perspective on these developments. From these narratives, the respondents also demonstrated their considerable ability to express themselves and their use of a range of persuasive techniques and abilities. The respondents also articulated the apparent authority of using systems based on the paradigmatic mode as represented by the use of, for example, SIGN guidelines.

However, in representing the use of various persuasive approaches, another recurrent narrative was drawn upon which discounted the activities of the nursing profession in the quality agenda. This process was recounted by a number of the respondents, sometimes with reference to their own history and by comparison with the activities of other health care professions.

The following section turns to a discussion of the findings, considered under three themes: involvement in clinical governance; accounts and accounting; and finally, discounting nursing.

7.2 Involvement in clinical governance

The importance of staff involvement in the clinical governance agenda is apparent from the policy statement which, whilst announcing that quality was to be placed at the centre of health care activity, also indicated that the delivery of high quality care was the:

responsibility of everyone working in the organisation, and is built upon partnership and collaboration within health care teams and between health care professionals and managers (Scottish Office, 1998, para. 16).

In this study, direct involvement in clinical governance was found to be limited to small groups of staff. The primary involvement identified was under the aegis of these groups situated in localities and responsible for conducting all aspects of projects related to this agenda. Inevitably this resulted in the majority of the nursing staff being located outside these groups, with their only direct involvement being through discussions of clinical governance and participation in various projects, including clinical audit. Thus involvement was through the development of systems resulting from the deliberations of a smaller group of nurses, who are viewed as an interpretative community. Consequently, significant themes in the narratives were the initial identification of these nurses and the processes used by the resultant groups to complete their activities. The use of small groups was found to be the primary means for progression of the agenda, with the participants' descriptions indicating a tacit acceptance of these groups advancing the initiative with no evidence of this mechanism being questioned. This reflects the clinical governance literature which also places reliance on groups to promote collaboration and agreement (Allen, 2000; Dewar, 2000); although in these the majority of groups are described as inter-disciplinary. The following sections turn to consideration of the identification of the group members and the roles with which they were identified.

7.2.1 Who was involved?

From the findings of this study, the community nursing account was produced by these project groups, and therefore membership was a consideration for managers and staff, although most were volunteers. Although personal interest was in many cases identified as the primary determinant, selection was also associated with the need to ensure representation of the different geographical locations and the involvement of staff nurses. Interestingly, this latter group was also identified on the basis of their knowledge of relevant topics, for example quality and audit. This made them the only group for whom a knowledge criterion for membership was noted. An alternative reading of the membership can be supplied by Lipsky's (1980, p. 3) concept of the "*street level bureaucrats*", for whom information was fundamental in order for the "*street level bureaucrat*" to be able to resist the goals of a manager of an organisation. Thus some respondents were found to participate in these groups on the basis of acquiring additional information. This provided the basis for them to choose to enact nursing policies in their own way, rather than follow the behest of senior nursing management.

Little has been written in relation to group membership in the context of clinical governance or in the quality management literature. As such, this study draws upon the analysis by Colebatch (1998) of policy implementation. Usefully, Colebatch considers the implementation of policy in terms of the vertical dimension where policy is considered to be coherent, instrumental and hierarchical. Contrasting with this, in the horizontal dimension policy is implemented and agreed in the contingent and contested context of organisations. It is in this latter dimension that the respondents can be conceived of as located and comprising relatively stable aggregates of staff, who were brought together to work on clinical governance. Whilst the membership comprised community nurses managers, and support nurses, they fulfilled a number of roles, amongst which Colebatch (1998) identifies experts, authority and maintenance.

The experts were identified as those having relevant knowledge: clinical, managerial, problem solving or related to clinical governance. Although the respondents self

confessed an interest in the clinical governance agenda, their involvement was also informed and subsequently justified by reference to the evidence based narrative current in the organisational setting. Expertise in the use of EBP is implied by the majority of respondents and linked, by some, with the development of clinical effectiveness. The growth of EBP and EBM has received increasing attention in the literature, with some authors suggesting a gradual dominance of this paradigm within health care (Harrison, 2002; Flynn, 2002; Walker, 2003). Harrison has, in a series of studies and analyses (Harrison, 2002; Harrison and Dowswell, 2002), developed a thesis depicting the gradual development of a scientific-bureaucratic approach to medical care. Whilst, acknowledging that this argument may be over determined, Harrison (2002) describes how a managerial discourse is gradually replacing the professional discourse, through the use of performance measures. Specifically, clinical governance and EBM guidelines are associated with a one best way philosophy and centralised approaches to management. Thus Harrison likens these health care reforms to Fordism. A similar point is also noted in Power (1997) who, whilst indicating the reliance of the medical profession on internal measures of performance, also notes the gradual managerial incursion into measuring clinical performance. EBP is among one of the most frequently mentioned means of conducting clinical governance. Following from Harrison's (2002) thesis, this suggests the penetration of community nursing by those rationalities associated with a managerialist perspective and EBP.

Harrison (2002) indicates that EBM was also associated with a concern for performance and continues by drawing from Lyotard's concept of performativity to refer, not only, to the increasing use of performance measures in society but also to the ability for this to become an internalised process:

because it has the potential to serve as an internal mode of legitimation for an activity (Harrison, 2002, p. 479).

Walker (2003) also cautions against the unthinking use of these systems which are reported as locking nursing:

into epistemic frames of reference that allow us only a limited (and limiting) view of health and health-care. Dangerous in that the established hierarchies of knowledge and power (in the form of bureaucratised medicine and an increasingly politicised healthcare system) are afforded the opportunity to reign unchallenged with the effect of marginalising and subordinating other, less authoritative knowledges and exercises of power (e.g. nursing's) (Walker, 2003, p. 153).

Traynor (1999) also indicates concern with increasing use of rational approaches to health care, and of a dualism existing between managers and clinical staff, related, in particular, to the divergent perspectives of management and the goals of the nursing profession. The managers were found to hold a managerialist perspective, and to draw from an "unarguable rationality" created by "financial constraint, New Right policy and the rise of technological surveillance" (Traynor, 1999, p. 158). In sharp contrast the community nursing staff were said to hold a subjectivist view based on self sacrifice, although Traynor also tempers this depiction by indicating that staff will jump out of the categories into which they are placed. There was nevertheless little consideration of the community nurses adopting a position held by managers or of them presenting the same arguments. Rather, Traynor notes that support for managerial perspectives among this group was "rare in the extreme" (Traynor, 1999, p. 138).

In contrast to Traynor's view and, perhaps worryingly, the rationalist agenda although not apparently perpetuating this managerial and practitioner divide, demonstrates the use of arguments based on an apparently "unarguable rationality". In this case the arguments of EBP and managerialism are demonstrated by the majority of nurses represented on these project groups. This finding follows that indicated by Latimer (1995), who refers to a predilection in the nursing profession to be "enrolled by, managerialist and performative devices in their organizing and identity work" (Latimer, 1995, p. 213).

The findings also demonstrated that, following from Degeling et al.'s (2004) observation, managers stood at the crossroads of the clinical and managerial domains

assisting in many instances with the construction of the clinical governance account. This is not surprising as they were influential in these processes at each stage of their delivery and were also the primary means whereby the nursing account, of clinical governance and community nursing, was heard on the multidisciplinary stage.

The authority of group members was also associated with the use of EBP and in furtherance of a concern with performativity, the group members were found to use the authority of the dominant paradigms within the clinical governance agenda as presented by Harrison (2002), to persuade other staff to use the relevant standards and audit tools. Thus the authority for the decisions made by these groups was found in a number of instances to be dependent on the use of EBP, with audit tools and guidelines underpinned by those from SIGN or similar organisations. This suggests that the group located at local level, was potentially acting as an agent of these paradigms, which can also be viewed as a form of the stories or scripts which Czarniawska (1997) identifies as existing within organisational settings. Although the authority of these groups was in some instances enacted by a manager, there was also a more subtle process of persuasion occurring, based on dominant narratives.

The final role proposed by Colebatch (1998) of maintenance was also apparent in these groups, associated in particular with the maintenance of standards and the audit processes. Some respondents noted that a considerable amount of time was spent undertaking literature searches and maintaining the evidence base of those standards which were extant. Thus the respondents appear to be acting in a caretaker role for the clinical governance systems, which is interesting in terms of work commitments. Consideration of this role is of use for drawing attention to the extent of work performed by the respondents with regard to updating and maintaining the audits and standards. The following section moves on to discuss the work of these groups in terms of developing accounts and the processes of accounting.

7.3 Accounts and accounting

The last section, by referring to the use of EBP and managerial precepts, indicated the role being performed by the respondents. Two forms of enactment are

considered, accounts and accounting. Firstly the development of the accounts of community nursing can be viewed as developing the technologies of accounts. Secondly an alternative view of accounting draws from Power's (1997) depiction of audit as a drama which acts to provide comfort, and also can be viewed as impression management.

7.3.1 *Accounts*

Tilley (2004) describes accounts as discursive events which both interpret a situation and thereby order events. These are therefore potentially powerful processes through which the groups establish boundaries and frame practice. This section considers the accounts in terms of normality and framing devices.

From the respondents' narratives it is apparent that the accounts produced are indeed discursive events, produced by the interpretive communities of the project groups, and in some cases discussion with the wider nursing community. In considering the development of the accounts underpinning clinical governance the primary areas of interest are the enactment and the stages of design. From this, there are a number of points to consider. Firstly the development of these acts can be viewed as providing or restoring normality, which Power (1997) and MacIntyre (1988) both indicate has been transformed. Previously, accounts were only provided for exceptional events. The recent development of interest in performance and audit has transformed this and accounts are provided for potentially any aspect of performance or social life. This provision of accounts must also be considered within the context of change presented by the respondents. In this case it could be argued that these clinical governance systems serve to provide stability and coherence in an unstable and uncertain social milieu. It is interesting to note that some respondents do indicate their view that standards and evidence should be provided for all aspects of practice. This indicates a somewhat worrying and unthinking approach to both the evidence based movement and clinical governance.

Power (1997) identifies two perspectives related to audit. First, the normative in which audit goals are described as vague although audit is presumed to be capable of

1.1.3 *Management reforms and community nursing*

The community setting was not immune to reform. The *NHS and Community Care Act* (Great Britain, 1990) implemented the Griffiths' recommendations (Griffiths, 1988) for community care. This resulted in the establishment of a mixed economy for care provision between the state, market, families, voluntary sector and GP Fundholders. The shift to the provision of care in the community continued under the subsequent government reforms (Scottish Office, 1998a; Scottish Executive 2000b), which also saw the creation of Primary Care Trusts (PCT) and Local Health Care Cooperatives (LHCC) (Scottish Office, 1997).

These developments have been described as creating organisational fragmentation and individualism, as well as engendering changes in the community nursing role, composition of the team and associated working practices (Symonds, 1998).

Amongst the changes in working practices of the community nurses were the increases in collaboration with a wider health and social care team and in assessing clients and delivering care, which resulted in the development of new flexible ways of working (Sines et al., 2001). Resultant from this differentiation between health and social care and the earlier discharge of patients from hospital, there has been an increase in the range of technical care delivered by the community nurses and an associated reduction in social care. The development of the skill mix (NHS Management Executive, 1993; McIntosh, 2000) and consequent employment of a growing number of junior and untrained staff, has resulted in district nurses delegating more clinical care and assuming an increased managerial and administrative role (Sines et al., 2001).

The following section turns to the literature which has analysed the government policies and the underpinning concepts of governance, quality and accountability.

1.2 **Defining governance, quality and accountability**

The management reforms challenged the idea that quality of health care was the preserve of the health professions, with gradual acceptance of the premise that health care quality could be measured, managed and continuously improved (Harrison and

delivering the goals. Secondly, it is suggested that the empirical world of audit practice is less concerned with the goals and more with the technical details of design and delivery. In this study it is proposed that the goals, whilst still vague, are nevertheless voiced by some respondents, a factor potentially associated with the longevity of the quality debate in health care as reported in the work of Harrison and Pollitt (1994) and Pollitt et al. (1998).

Enacting clinical governance requires the use of interpretative skills and the groups can be viewed as interpretative communities. The stages of clinical governance are delivered collaboratively by the groups and include project selection, design and analysis. The previous section identified the reliance on EBP and other managerial rationalities, a point also argued convincingly by Traynor (1999) and MacIntyre (1985). These rationalities nevertheless require translation into processes and systems for use in community nursing, which could be considered using Llewellyn's (2003) terms of practical theorising, the level of conceptual development where "individuals make things happen through resources" (2003, p. 687). At this level concepts are dealt with through activities which Morgan (1986) and Colebatch (1998) identify with the use of problem solving techniques and other means of analysis. These are drawn from the surrounding organisational and professional context and with the processes facilitated by group members, as reported by managers and one support nurse. Thus some staff are presented as being in a position to influence the stages of framing and designing the systems of clinical governance. The literature related to quality and clinical governance in health care, in particular Degeling et al. (2004), Harrison and Dowswell, (2002) and Llewellyn (2001), noted the position of medical and nursing managers in the middle of clinical and managerial domains.

Harrison and Pollitt (1994) identify as an area of concern the nurse managers' opening of nursing to the managerial gaze. In contrast, Degeling et al. (2004) view the managers as the translators of managerial goals and clinical governance. In particular, nurse managers are viewed as becoming proficient in the skills required for promoting these developments.

This framing of clinical governance projects was found to involve all grades and to draw from the dominant paradigms in the community context. These include EBP, SIGN, CSBS and also, interestingly, the subdivision of nursing into a sequence of tasks. McIntosh (2000) highlights a concern with the division of community nursing practice into tasks, which is associated with the development of a skill mix in the community. A point of some note is that, whilst the managers placed particular emphasis on the use of critical analysis, there was little evidence of the frames of reference being objectively appraised by those nurses applying them. This is similar to Morgan's (1986) comment related to enactment in organisational contexts, which is frequently based on the proactive and yet unthinking use of available scripts and narratives from the surroundings. It might also be considered that as MacIntyre (1988) has proposed, it is difficult for some groups to muster the debate against those who have considerable skill with argument and have indeed made the profession of their position synonymous with their role. The skills underpinning these developments are drawn, in the main, from a mode of cognition, described by Bruner (1986) as the paradigmatic mode in which reliance is placed on calculative systems and scientific rationality. Power (1997) describes this further as comprising the use of procedures and techniques for making auditing and accounting systems work.

In designing these systems the respondents were found to place considerable emphasis on the language and terms used to produce measurable criteria. Language and the use of language evidently occupy a central place in the enactment processes, with the respondents not seeming to consider that the choice of criteria labels nursing practice. This accords with a point raised by Power (1997) whereby auditing processes serve to label practice and thereby reduce dialogue and sharing. The audit systems, due to a perceived basis in a scientific approach, were viewed as portable and applicable to any setting (Power, 1997). From this it is evident that the account proposed by the majority of respondents contrasts with the approach to audit evidenced by Kerrison et al. (1993; 1994) in which the emphasis was placed on audit as a heuristic device. Rather, the concern evidenced by the respondents was to develop accounts which provided for the control of community nursing practice. Thus the respondents were found to describe the development of managerial systems

as supporting clinical governance and the standardisation of nursing practice across the localities. The rationale provided for this latter development was argued on the basis of enabling staff movement between localities, the unarguable rationality of risk management and supporting staff nurses through the use of agreed standards and protocols.

7.3.2 Accounting: impression management

This section considers an alternative reading of the processes associated with developing clinical governance and accounting. In this view it is proposed that despite the apparent concern with scientific methods and the development of measures, there was in fact more concern with the outward appearance of delivery. Power (1997) likened audit to a drama which was intended to provide comfort. In translating this argument to community nursing, it provides an explanation for continuing to follow a path of implementation in which too few staff are attempting, or appear to be attempting, to involve all staff in these processes. Many of the respondents' accounts were therefore associated with difficulties of being under resourced, lacking direct specialist assistance and, in some instances, the education and training to advance the agenda. Nevertheless, by viewing these nurses as working within Bruner's (1986) narrative paradigm, in trying to persuade the wider group to become involved, they are themselves actively creating a narrative of accounting. It was one, moreover, which could not be completed. The potential visibility of these respondents may also relate to the constant use of the word "looking" by all respondents, with reference to clinical governance. Thus the accounting narrative may serve to provide an impression of the community nursing service as conducting clinical governance and of community nurses constantly "looking" and checking their practices.

7.4 The discounted profession

This final stage of the discussion is concerned with a narrative treated by the respondents and following from Polkinghorne (1988), which can be termed regressive. Polkinghorne has described the use of narratives in providing an explanation of who we are, what we are doing and, at a cultural level, to provide

cohesion and transmit values. The following theme of discounting relates to the recurrent use of stories and accounts which discount the activities of nursing and nurses, in particular related to quality and standard setting initiatives. Some of these themes were provided by the managers interviewed, but other grades were not exempt, particularly in terms of self-denigration. This narrative is of interest given the prevalence and treatment of this theme, together with the strength of opinion in the account.

To return to Polkinghorne (1988), he also notes the ability of narratives to construct a past which explains the 'now'. There was evidence of this within the narratives, particularly with reference to the implementation of standard setting initiatives by the nursing profession. In two accounts, both provided by managers but working in different organisations, there was a similarity in the descriptions of the distance of the nursing standards from practice, conveyed by isolated authors and shelved folders. These systems were found to have failed, gone out of date too easily and overall are presented as lacking relevance. In casting the earlier initiative in this fashion, it evidently serves as a narrative device to promote the current, new system. Similarly, the historical discounting was continued with a theme of nursing having been permitted to carry on with their "little" quality projects, although who was permitting them was not made clear. By contrast, a support nurse sets the scene for the other health professions coming on board with the quality developments. The suggestion is offered that the new processes would be more reasoned with a picture presented of staff sitting and discussing developments.

The respondents also provided a view of their own performance in earlier initiatives, which were constantly viewed as difficult. Thus overall, the historical account of nursing involvement in standard setting attributed little respect to the work of those staff who had been involved. This view travelled over to the "now" in which nurses were seen to have difficulties with the evidenced based practice agenda. However, one manager provided some sense of balance by offering the opinion that this was the latest "in" thing.

The position of the nursing profession within the health care organisation was also viewed as weak and having a voice which was not heard. This was interestingly paradoxical given the obvious ability to narrate their position during these interviews.

This position of a weak and subjugated nursing profession recalls Traynor's description of the community nurses, although in this instance it is being applied by the nurses to themselves. Thus, the nursing majority are positioned by the respondents in a marginalised role. It is clear that this positioning is a narrative device used to explain the actions of the respondents. However, at times, particularly strong opinions are voiced, depicting them as incestuous when working in their teams.

Although being isolated or marginalised is a view which can be applied to the descriptions of the nursing majority, from these narratives it also applies to the nursing profession. An interesting point is the comparative absence of clinical governance initiatives involving nurses in multi-disciplinary activities, other than some involvement with organisational accreditation. Thus nursing could indeed be seen to lack a voice across the organisation, other than that afforded by the nurses and managers who occupied positions in Trust and locality groups and, as such, provided the account of community nursing to the wider community.

7.5 Implications of the study

By using a narrative approach drawing from Morgan (1986) and MacIntyre's (1985) conceptualisation of an enacted narrative, attention has been drawn to the performative aspects of community nursing and notably those used to frame, construct and explain the activities of nurses across diverse settings. This approach has also demonstrated the range of skills and factors involved in these processes. The agency of the respondents was of particular interest, spanning as it did both aspects of Bruner's (1986) two modes of cognition, namely the paradigmatic and the narrative. Thus the nurses were found to utilise both the calculative skills and those

of story telling, with remarkable facility in both of these modes exhibited by some respondents.

The implications of the study for nurses, managers, education and research are considered in the following sections. In the first instance the implications for nurses and managers are combined as they were in the thesis and it would seem perverse to arbitrarily restore the dualism at this stage. Another consideration in the following discussion is to retain awareness of the prevalence and apparent ubiquity of the discounting theme in narratives and avoid the processes of discounting of the nursing profession and nurses; which formed a recurrent theme in some of the enacted narratives.

In the following section three primary themes are considered: change and control; marginalisation; and finally, the nursing voice.

7.5.1 Community nursing and community management

The respondents were identified as undertaking the complex tasks of conceptualising practice against a variety of analytics. Despite this evident skill and commitment to constructing systems of clinical governance, which were intended to improve the quality of care, there was an evident theme of centralising control and standardising nursing care. Whilst, as was noted, the systems may have been more apparent than real there was nevertheless a worrying trend towards the development of quality control. This was driven by managerialist precepts which were failing to hear the other voices included in the narrative and also failed to listen to the respondents' own account of change. Thus the respondents indicated a cycle of recurrent change which required staff to adapt and resulted in potentially anomalous clinical governance systems. A number of nurses commented on the need to be aware of the wider picture, as noted by the following nurse:

I think you have to be someone that has, well you have to have a clear idea of district nursing and where it's going, and also have a lot of knowledge of what's needed. What you know, what is it that district nursing needs to look at.

Because a lot of people have no idea (District Nurse 3, Trust 2).

These systems may have been developed in order to establish a feeling of some continuity and control, however there are questions as to the long term impact of this approach for the nursing profession. Interestingly, there were examples given by nurses who were themselves involved in the development of standards and who indicated that these were too restrictive to use during client-nurse interactions.

An additional aspect of the development of the clinical governance account was that of marginalisation. Evidently, many of the staff were excluded from stages of these developments, despite the attempts of the group members to involve them with these processes. Thus the majority of the nurses were found to stand outwith the decision making which is further complicated by a paradox identified by Power (1997). In this example Power notes that although the goals of accountability systems may drive towards openness, paradoxically the very means and techniques used serve to exclude staff members further. Thus marginalisation presents a challenge to those staff charged with promoting these and similar developments. Interestingly, the marginalisation conundrum does not stop at this point due to the fact that we are all part of another person or group's story (MacIntyre, 1985). As a result the nurses were themselves depicted as excluded and marginalised from other groups in the community setting and, moreover, described as implementing systems which impacted on community nursing. Thus we are all "the others" and consideration is required not only of the means of communication, but also the impact of the systems which are developed and the inadvertent exclusion that may arise from the processes of framing and designing.

Thus the comments regarding critical analysis and skills in appraisal were of particular concern, given the apparent inability of the nurses and managers to critically analyse the frames they were using to develop clinical governance and clinical audit accounts. The framing devices in use were, in the main, significant for providing analytics based on managerial and task oriented perspectives. There was an evident absence of nursing models and where models were used, they reflected

the patient as on a journey or series of stages, an approach recommended by Degeling, Maxwell and Iedema, (2004a) for the development of clinical governance systems. This is a significant finding and indicates an area for future consideration, particularly given the evident facility of the reported group with formulating and enacting this particular account within the calculative paradigm. Consideration of the power of the accounts we frame for ourselves and others seems crucial.

Finally it is proposed that as a means of dealing with these issues, attention should be paid to the skills evidenced in this study and in particular to the facility of the nursing voice. Despite the respondents' recurrent interpretation as to the lack of nursing voice, they themselves were evidently exhibiting skills in these very processes. The focus was perhaps erroneously on the skills themselves rather than on the opportunity to enter the forum where they can both be heard and participate. Thus Burke (1969) proposes the use of a dialectical approach and acceptance of the inevitable contradictions and ambiguities in social life. He seeks to promote the fora where all voices may be heard.

7.5.2 Nurse education

There are implications in this study for education arising from the respondents' observations on the training and education they have received. One reading of the findings of this study may be the possibility that these initiatives are concerned with achieving the maximum effect for the minimum outlay of resources. However, it is probable that attention to the training and development needs associated with this agenda, will benefit the patients and staff. Thus it is suggested that planned programmes of education and training should be developed which focus, not on the latest initiative, but on the transferable skills and knowledge required to deal with new developments. These include facilitating groups, analysing data and other skills common to change programmes and project management. It is also proposed that educationalists should consider the development of programmes, which facilitate the abilities of community nurses in critical analysis related to the conceptualisation of clinical governance, and those processes concerned with implementation.

7.5.3 Implications for further research

The use of an approach considering the performative aspects of organisational contexts has proven useful for eliciting nursing voices and, in particular, provided the ability to present these as a metanarrative across organisational settings. Individuals and groups were found to be the bearers of narratives which they, simultaneously, constructed and reconstructed. This was particularly apposite in the context of a change project: to hear the voices on this subject and to view the means whereby an explanatory basis was constructed for future actions. The most obvious example of this was the respondents' construction of the context of change as the backdrop for the implementation of clinical governance. The study raises the question whether this approach could be applied in other health care contexts and, given the evidently performative nature of much of the nursing role, this is certainly a possibility.

Due to the nature of the research method, the narratives collected were set at the level of capturing initial information. Whilst this had evident advantages for the overview of the community setting and breadth of material obtained, there were also disadvantages with this approach. These include: the lack of opportunity to elicit the processes whereby groups of nurses engage in creating narrative accounts, in particular, those used to construct clinical governance; and the need to consider the interplay between the triad of organisational, managerial and professional structures, and the agency of the individual community nurses. These factors may be addressed by the use of alternative research designs, respectively, the case study (Feagin et al., 1991; Stake, 2000) and an approach based on triangulation (Denzin, 1989; Shih, 1998; Coyle and Williams, 2000; Kelle, 2001).

Stake (2000) describes the use of case studies not as a methodological choice, but as being concerned with what is to be studied. It is proposed, therefore, that a longitudinal case study be used, to examine the involvement of a community nursing team in the development of clinical governance. This design will facilitate examination of all nursing perspectives within the team, including those staff members who may be uninterested in developments. Amongst the strengths of this approach is the development of an in-depth and multifaceted investigation, through

the use of a wide range of research methods including observation, interviews and “archival research” (Warner, 1991, p. 182). The design also permits the development of a holistic view of the team, by consideration of team actions, interactions between team members, other staff groups and the influence of social networks. Thus through the use of a case study design the findings will be grounded in the community nursing setting. Furthermore, the use of a longitudinal design for the case study will enable consideration of the dimensions of time and change; this will also allow the researcher to identify significant points in the construction of clinical governance by the team. Finally, although the findings of the study would be specific to the case, this approach promotes investigation and the identification of new ideas, enabling theoretical innovation which can be generalised to other cases (Orum et al., 1991).

The second research design proposes the use of between-method triangulation, to examine the interplay between structural constraints and the agency of community nurses involved in the implementation of clinical governance. Triangulation has been described as an “epistemological claim concerning what more can be known about a phenomenon” (Moran-Ellis, 2006, p. 47), and achieved by combining two or more data sources, methods, theories or researchers (Denzin, 1989). The use of triangulation presents complex epistemological, theoretical and methodological issues, as evidenced by the nursing and social science literature (Shih, 1998; Foss and Ellefsen, 2002; Cox and Hassard, 2005; Moran-Ellis et al., 2006). The specific form of triangulation proposed here is between-method triangulation which, by combining the use of qualitative and quantitative data in the same study (Shih, 1998; Kelle, 2001), can be used to examine interactions between the macro and micro levels of the organisational setting. Through use of this design, quantitative data would be used to map the community nursing staff involvement in clinical governance activities across an organisational setting. The data set would be pertinent to the staff group; for example, length of service, nursing role, professional and educational qualifications and skill mix. These data would be used to inform the collection and analysis of ethnographic data, concerned with the involvement of community nurses in the development of clinical governance projects. Amongst the advantages of this design would be the ability to develop a more complete picture of

Pollitt, 1994). This section draws from policy analysis to identify the key features and traces the development of the three concepts of governance, quality, and accountability.

1.2.1 *Defining governance*

It is evident that governance and clinical governance are at an early stage of theoretical development (Kooiman, 1993; Rhodes, 1997; Pierre and Peters, 2000; Newman, 2001; Harrison, 2002; Flynn, 2002; Bevir et al., 2003, 2003a). The literature evidences a concern with defining the term governance, from which it is apparent that although governance shares the same linguistic root as government it is not a synonym for government, but is said to signify “a *new* process of governing; or a *changed* condition of ordered rule; or the *new* method by which society is governed” (Rhodes, 1997, p. 46). The word is derived from the Greek “kybernan” meaning to steer and “kybernetes” helmsman (OED, 1989), which also provides the root of the word cybernetics, the science of control (Pierre and Peters, 2000). Thus governance may refer to steering or to control (Osborne and Gaebler, 1992). The term has been described as confusing (Pierre, 2000), ambiguous and imprecise (Hirst, 2000, p. 14) as well as a “hard-working and overused concept” (Newman, 2001, p. 16). Similar terminological difficulties are evident in the clinical governance literature, with Gray and Harrison (2004, p. 3) stating that a striking feature of the reforms is “the vagueness of the notion of governance employed”, and Walshe et al. observing that the “definition of clinical governance is unbounded and often contested, so different people mean different things by it” (Walshe et al., 2003, p. 6).

These etymological and conceptual difficulties have not diminished interest in the topic of governance, with increasing interest evidenced by analysts. Among the explanations given for the development of new forms of governance are the financial crisis of the state, marketisation, ongoing social change and the management revolution in the public sector (Rhodes, 1997; Pierre and Peters, 2000; Newman, 2001). These are described as resulting in a “change in the meaning of government” (Rhodes, 1997, p. 15) and a “post-political search for effective regulation and accountability” (Hirst, 2000, p. 13) with a resultant shift in government, enacted

the social processes occurring in complex organisational structures; including the identification of structural constraints on individual staff members and of those situations where an individual can be seen to have influenced a particular decision for community nursing.

Finally, there is an evident requirement that scholarly attention be focused on the involvement of nursing staff in both current and future reforms (Rafferty, 1992; West and Scott, 2000). In order to achieve this it is proposed that nurse researchers seek to build disciplinary bases for the profession in the fields of policy and organisational research.

7.6 Conclusion

The construction of this enacted narrative is that of the researcher and is one among many potential readings, which could have been obtained from the material. It is considered however, that this narrative reflects the developments, events and means used by nursing staff in their conceptualisation of clinical governance.

This research presents a view of the development of accounts related to the clinical governance agenda, by nurses in the community setting. It has demonstrated the skills and processes involved, including the benefits and problems for individuals, nursing groups and the profession. Developing formal accounts is an inevitable aspect of the role of nurses and managers; and the means used to collaborate in this have also been exhibited and explored. Within the managerial agenda of the health service, accounts have assumed a new focus and purpose. It is the conclusion of this thesis that the members of the nursing profession, including all levels and roles, should consider their involvement in these processes. In addition, these issues should be considered as being of more import than learning and applying discrete technical skills, for their potential impact beyond individual clinical settings is substantial.

In conclusion, through the medium of this research, we have been privileged to hear the voices of those members of staff involved in the construction of clinical governance. As MacIntyre (1988) states, we live with our:

own specific modes of social relationship, each with its own canons of interpretation and explanation in respect of the behavior of others, each with its own evaluative practices (1988, p. 391).

We should use, therefore, our encounters with others, for self-recognition and self-knowledge.

Literature

- Abbott A. (1988) *The System of Professions: An Essay on the Division of Expert Labor*. The University of Chicago Press, Chicago.
- Allen P. (2000) Accountability for clinical governance: developing collective responsibility for quality in primary care. *British Medical Journal* **321**, 608-611.
- Annandale E. (1996) Working on the front-line: risk culture and nursing in the new NHS. *The Sociological Review* **44**(3), 416-451.
- Aristotle (trans. 1991) *The Art of Rhetoric* (H. C. Lawson-Tancred, Transl.). Penguin, London.
- Atkinson P. (1997) Narrative turn or blind alley? *Qualitative Health Research* **7**(3), 325-344.
- Atkinson P. (2005) Qualitative Research – Unity and Diversity. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* [On-line Journal] **6**(3) <<http://www.qualitative-research.net/fqs-texte/3-05/05-3-26-e.htm>> accessed 14 August 2006.
- Atkinson P. and Silverman D. (1997) Kundera's Immortality: the interview society and the invention of the self. *Qualitative Inquiry* **3**(3), 304-325.
- Baggaley S. and Bryans A. (2004) Accountability in Community Nursing. In S. Tilley and R. Watson (eds.) *Accountability in Nursing and Midwifery* (2nd edn.) (pp. 143 - 156). Blackwell Science Ltd, Oxford.
- Baker R., Lakhani, M., Fraser R. and Cheater F. (1999) A model for clinical governance in primary care groups. *British Medical Journal* **318**, 779-783.
- Bank J. (1992) *The Essence of Total Quality Management*. Prentice Hall, Hemel Hempstead.
- Barry D. and Elmes M. (1997) Strategy Retold: Toward a Narrative View of Strategic Discourse. *Academy of Management Review* **22**(2), 429-452.
- Barthes R. (trans. 1977) *Image Music Text* (S. Heath, Transl.). Fontana Press, London.

- Batey M.V. and Lewis F.M. (1982) Clarifying Autonomy and Accountability in Nursing Service: Part 1. *The Journal of Nursing Administration* **12**(9), 13-18.
- Berg M. (1997) "Problems and Promises of the Protocol". *Social Science and Medicine* **44**(8), 1081-1088.
- Berger P.L. and Luckmann T. (1967) *The Social Construction of Reality*. Penguin Books, London.
- Bevir M. and Rhodes R.A.W. (2003) *Interpreting British Governance*. Routledge, London.
- Bevir M. and Rhodes R.A.W. (2003a) Searching for civil society: Changing patterns of governance in Britain. *Public Administration* **81**(1), 41-62.
- Bevir M., Rhodes R.A.W. and Weller P. (2003) Comparative Governance: Prospects and Lessons. *Public Administration* **81**(1), 191-210.
- Bevir M., Rhodes R.A.W. and Weller P. (2003a) Traditions of Governance: Interpreting the Changing Role of the Public Sector. *Public Administration* **81**(1), 1-17.
- Bloor K. and Maynard A. (1998) *Clinical Governance: Clinician, heal thyself?* Institute of Health Services Management, London.
- Bochner A.P. (2001) Narrative virtues. *Qualitative Inquiry* **7**(2), 131-157.
- Boden L. and Kelly D. (1999) Clinical governance: The route to (modern, dependable) nursing research? *NTRsearch* **4**(3), 177-188.
- Boland R.J. and Schultze U. (1996) Narrating accountability: cognition and the production of the accountable self. In R. Munro and J. Mouritson (eds.) *Accountability, Power, Ethos and the Technologies of Managing* (pp. 62-81). International Thomson Business Press, London.
- Bruner J. (1986) *Actual Minds, Possible Worlds*. Harvard University Press, London.
- Bruner J. (1990) *Acts of Meaning*. Harvard University Press, London.

- Buetow S.A. and Roland M. (1999) Clinical governance: bridging the gap between managerial and clinical approaches to quality of care. *Quality in Health Care* 8, 184-190.
- Burchill G., Gordon C. and Miller P. (1991) *The Foucault Effect Studies in Governmentality*. The University of Chicago Press, Chicago.
- Burke K. (1950) *A Rhetoric of Motives*. Prentice Hall, New York
- Burke K. (1966) *Language as Symbolic Action: Essays on Life, Literature, and Method*. University of California Press, London.
- Burke K. (1968) Dramatistic method. In J.R. Gusfield (ed.) (1989) *Kenneth Burke on symbols and society* (pp. 135-138). University of California Press, London.
- Burke K. (1969) *A Grammar of Motives*. University of California Press, Los Angeles.
- Burnes B. (1992) *Managing Change: a strategic approach to organisational development and renewal*. Pitman, London.
- Burrell G. and Morgan G. (1979) *Sociological Paradigms and Organisational Analysis*. Heinemann Educational Books, Portsmouth, NH.
- Butler J. (1994) Origins and early development. In R. Robinson and J. Le Grand (eds.) *Evaluating the NHS reforms* (pp.13-23). King's Fund Institute, Newbury.
- Cadbury A. (1992) *Financial Aspects of Corporate Governance*. [Cadbury Report] Gee and Co. Ltd., London.
- Cameron K.S. and Barnett C.K. (2000) Organization Quality as a Cultural Variable: An Empirical Investigation of Quality Culture, Processes, and Outcomes. In R.E. Cole and W.R. Scott (eds.) *The Quality Movement & Organization Theory* (pp. 271-294). Sage Inc., Thousand Oaks, CA.
- Centre for the Evaluation of Public Policy and Practice (CEPP) (1991) *Evaluation of the Total Quality Management Projects in the National Health Service: First interim report to Department of Health*. Brunel University, Uxbridge.
- Clarke J. and Newman J. (1997) *The Managerial State: Power, Politics and Ideology in the Remaking of Social Welfare*. Sage Publications Ltd., London.

Clinical Standards Board for Scotland (2001) *Clinical Standards Generic*. NHS Scotland, Edinburgh.

Cole R.E. and Scott W.R. (eds.) (2000) *The Quality Movement and Organization Theory*. Sage Inc, Thousand Oaks, CA.

Colebatch H.K. (1998) *Policy*. Open University Press, Buckingham.

Cox J.W. and Hassard J. (2005) Triangulation in organizational research: a representation. *Organization* **12**(1), 109-133.

Coyle J. and Williams B. (2000) An exploration of the epistemological intricacies of using qualitative data to develop a quantitative measure of user views of health care. *Journal of Advanced Nursing* **31**(5), 1235-1243

Courpasson D. (2000) Managerial Strategies of Domination: Power in Soft Bureaucracies. *Organization Studies* **21**(1), 141-161.

Currie L., Morrell C. and Scrivener R. (2003) *Clinical Governance: an RCN resource guide*. Royal College of Nursing, London.

Czarniawska B. (1997) *Narrating the Organization Dramas of Institutional Identity*. The University of Chicago Press, Chicago.

Czarniawska B. (1998) *A Narrative Approach to Organization Studies*. Sage Publications Ltd., London.

Czarniawska B. (1999) *Writing Management Organization Theory as a Literary Genre*. Oxford University Press, Oxford.

Czarniawska B. (2004) Metaphors as enemies of organizing, or the advantages of a flat discourse. *International Journal of the Sociology Language* **166**, 46-65.

Czarniawska B. (2004a) *Narratives in Social Science Research*. Sage Publications Ltd., London.

Czarniawska-Joerges B. (1996) Changing Times and Accounts: Tales From an Organization Field. In R. Munro and J. Mouritson (eds.) *Accountability, Power, Ethos and the technologies of managing* (pp. 307-328). International Thomson Business Press, London.

- Davies B. and Harré R. (1991) Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour* **20**(1), 43-63.
- Davies H.T.O. and Mannion R. (1999) *Clinical Governance: striking the balance between checking and trusting*. Discussion Paper 165. Centre for Health Economics, University of York, York.
- Day P. and Klein R. (1983) The Mobilisation of Consent versus the Management of Conflict: Decoding the Griffiths Report. *British Medical Journal* **287**, 1813-1816.
- Day P. and Klein R. (1987) *Accountabilities: five public services*. Tavistock Press, London.
- Dean J.W. and Bowen D.E. (2000) Management Theory and Total Quality: Improving Research Through Theory Development. In R.E. Cole and W.R. Scott (eds.) *The Quality Movement and Organization Theory* (pp. 3-21). Sage Inc., Thousand Oaks, CA.
- Degeling P., Kennedy J. and Hill M. (2001) Mediating the cultural boundaries between medicine, nursing and management - the central challenge in hospital reform. *Health Services Management Research* **14**(1), 36-48.
- Degeling P., Kennedy J., Macbeth F., Telfer B., Maxwell S. and Coyle B. (2004) Practitioner Perspectives on Objectives and Outcomes of Clinical Governance: Some Evidence from Wales. In A. Gray and S. Harrison (eds.) *Governing Medicine: Theory and Practice* (pp. 60-77). Open University Press, Buckingham.
- Degeling P., Maxwell S. and Iedema R. (2004a) Restructuring Clinical Governance to Maximize its Developmental Potential. In A. Gray and S. Harrison (eds.) *Governing Medicine: theory and practice* (pp. 163-179). Open University Press, Maidenhead.
- Degeling P., Maxwell S., Kennedy J. and Coyle B. (2003) Medicine, management, and modernisation a "danse macabre"? *British Medical Journal* **326**, 649-652.
- Denzin N. (1989) *The Research Art: A Theoretical Introduction to Sociological Methods* (3rd edn.). Aldine, Chicago.

- Denzin N.K. and Lincoln Y.S. (eds.) (2000) *Handbook of Qualitative Research* (2nd edn.). Sage Publications Ltd., London.
- Department of Health (1989) *Working for Patients*. Cm 555, HMSO, London.
- Department of Health (1989a) *Medical Audit Working Paper no. 6. Working for Patients*. HMSO, London
- Department of Health (1989b) *Caring for People: community care in the next decade and beyond*. CM 849, HMSO, London
- Department of Health (1991) *The Patient's Charter*. HMSO, London
- Department of Health (1997) *The New NHS: Modern - Dependable*. Cmnd 3807. The Stationery Office, London.
- Department of Health (1998) *A First Class Service: Quality in the New NHS*. 1998/113. Department of Health, London.
- Department of Health (1999) *Making a difference, strengthening the nursing, midwifery and health visiting contribution to health and health care*. Department of Health, London
- Department of Health and Social Security (1983) *The NHS Management Inquiry, Griffiths Report*. HMSO, London.
- Department of Health and Social Security (1986) *Health Services Management: Resource Management (Management Budgeting) in Health Authorities*. Circular HN(86)34, HMSO, London
- Dewar S. (1999) *Clinical Governance under Construction: Problems of design and difficulties in practice*. Kings Fund, London.
- Dewar S. (2000) Collaborating for quality: the need to strengthen accountability. *Journal of Interprofessional Care* **14**(1), 31-38.
- Dickens P. (1994) *Quality and Excellence in Human Services*. John Wiley, Chichester.
- Donaldson L.J. (1998) Clinical governance; a statutory duty for quality. *Journal of Epidemiology and Community Health* **52**(2), 73-74.

- Donaldson L.J. and Gray J.A.M. (1998) Clinical governance: a quality duty for healthcare organisations. *Quality in Health Care* 7 (Suppl), S37-44.
- Duff L. (1995) Standards of care, quality assurance and accountability. In R. Watson (ed.) *Accountability in Nursing Practice* (pp. 49-69). Chapman & Hall, London.
- Dunlop A. (1998) *Corporate Governance and Control*. CIMA, London.
- Eco U. (1992) *Interpretation and overinterpretation*. (S. Collini, ed.). Cambridge University Press, Cambridge.
- Edley N. (2001) Unravelling Social Constructionism. *Theory & Psychology* 11(3), 433-441.
- Elliott H. and Popay J. (2000) How are policy makers using evidence? Models of research utilisation and local NHS policy making. *Journal of Epidemiology and Community Health* 54(6), 461-468.
- Ellis R. and Whittington D. (1993) *Quality Assurance in Health Care: A Handbook*. Edward Arnold, London.
- Feagin J.R., Orum A.M. and Sjöberg G. (eds.) (1991) *A Case for the Case Study*. The University of North Carolina Press, Chapel Hill, NC.
- Ferlie E.B. (1997) Large Scale Organisational and Managerial Change in Health Care: A Review of the Literature. *Journal of Health Services Research Policy* 2(3), 180-189.
- Ferlie E.B., Ashburner L. and Fitzgerald L. (1995) Corporate Governance and the Public Sector: Some issues and evidence from the NHS. *Public Administration* 73(3), 375-392.
- Ferlie E.B. and Shortell S.M. (2001) Improving the Quality of Health care in the United Kingdom and United States: A Framework for Change. *The Milbank Quarterly* 79(2), 281-315.
- Flynn R. (2002) Clinical governance and governmentality. *Health, Risk & Society* 4(2), 155-173.
- Flynn R. (2004) 'Soft Bureaucracy', Governmentality and Clinical Governance: Theoretical Approaches to Emergent Policy. In A. Gray and S. Harrison (eds.)

Governing Medicine: Theory and Practice (pp. 11-26). Open University Press, Maidenhead.

Foss C. and Ellefsen B. (2002) The value of combining qualitative and quantitative approaches in nursing research by means of method triangulation. *Journal of Advanced Nursing* **40**(2), 242-248.

Foucault M. (1977) *Discipline and Punish* (A.M. Sheridan-Smith, Transl.). Penguin, London.

Foucault M. (1991) Governmentality. In G. Burchill, C. Gordon and P. Miller (eds.) *The Foucault Effect* (pp. 87-104). The University of Chicago Press, Chicago.

Franks A. (2001) How goes the night, watchman? An overview of the first annual clinical governance reports (1999/2000) from acute trusts in an English NHS region. *Journal of Management in Medicine* **15**(3), 220-226.

Freeman T. (2003) Measuring progress in clinical governance: assessing the reliability and validity of the Clinical Governance Climate Questionnaire. *Health Services Management Research* **16**(4), 234-250.

Freeman T., Latham L., Walshe K., Spurgeon P. and Wallace L. (1999) *The early development of clinical governance: A survey of NHS trusts in the South West Region*. [Project report no. 12]. Health Services Management Centre, Birmingham.

Gabe J., Kelleher D. and Williams G. (1994) *Challenging Medicine*. Routledge, London.

Gamble A. (2000) Economic Governance. In J. Pierre (ed.) *Debating Governance: Authority, Steering and Democracy* (pp.110-137). Oxford University Press, Oxford.

Garfinkel H. (1967) *Studies in Ethnomethodology*. Prentice-Hall, New Jersey.

Glennerster H., Owens P. and Kimberly A. (1986) *The Nursing Management Function after Griffiths in the North West Thames Region: an interim report*. NWT & LSE, London.

Glennerster H. and Owens P. (1987) *The Nursing Management Function after Griffiths: Second Interim Report*. NWT & LSE, London.

through the traditional top down authority of the state, to the development of alternative forms of governance. Peters (2000) contends that the current interest in governance is primarily associated with a state centric view, accepting that society must be governed and seeking to answer the question as to whether the state or society will be the dominant partner. In response to this interest, theorists have identified various forms of governance with Bevir and Rhodes (2003) providing a comprehensive list of seven types: corporate governance, new public management (NPM), good governance based on the World Bank criteria, international interdependence, socio-cybernetic systems, new political economy and self-organising networks.

Power (1997) also provides a model drawing together some of the aspects noted above and suggesting that governance entails a combination of management initiatives, each concerned with the “programmatically reconstructing of organizational life” (1997, p. 10) and with pushing control further into organisational structures. This new rationality is based on three interrelated programmes. Firstly, NPM which emphasises private sector management styles, explicit standards, measures of performance and improving organisational performance by the development of the organisational culture, leadership, and motivating staff (Hood, 1991); secondly, an increase in regulatory initiatives such as corporate governance; and finally, the development of quality management systems, such as Total Quality Management (TQM) and Quality Assurance (QA). Each of these management developments has featured in recent health service reforms (Pollitt, 1993; Ferlie et al., 1995; Clarke and Newman, 1997; Walshe et al., 2000).

The last description of clinical governance considered in this section is that provided by Donaldson and Gray (1998) who state that “governance implies control and it is obvious that controls are needed” (Donaldson and Gray, 1998, S41), with the authors adding that the main issue of concern is the balance achieved between self-control and control by others. In practical terms, three systems were identified with the development of this control: the processes which mirror the rigour and accountability of the corporate governance arrangements; continuous quality improvement; and the

- Grainger C., Hopkinson R., Barrett V., Campbell C., Chittenden S., Griffiths R., Low D., Parker J., Roy A., Thompson T. and Wilson T. (2002) Implementing clinical governance - results of a year's programme of semi-structured visits to assess the development of clinical governance in West Midlands Trusts. *British Journal of Clinical Governance* 7(3), 177-186.
- Gray A. and Harrison S. (2004) *Governing Medicine: Theory and Practice*. Open University Press, Maidenhead.
- Great Britain (1990) *National Health Service and Community Care Act 1990*. Chapter 19. HMSO, London.
- Green J. and Thorogood N. (1998) *Analysing Health Policy. A Sociological Approach*. Longman, London.
- Griffith R. and Tegenah C. (2005) The law and accountability in district nursing practice. *British Journal of Community Nursing Practice* 10(7), 339-343.
- Griffiths R. Sir (1988) *Community Care: agenda for action; a report to the Secretary of State for Social Services*. HMSO, London.
- Gusfield J.R. (1989) *Kenneth Burke on symbols and society*. The University of Chicago Press, Chicago.
- Gusfield J.R. (1989a) The Bridge over Separated Lands: Kenneth Burke's Significance for the Study of Social Action. In H.W Simons and T. Melia (eds.) *The Legacy of Kenneth Burke* (pp. 28-54). The University of Wisconsin Press, Madison.
- Habermas J. (1971) *Towards a Rational Society: Student Protest, Science and Politics* (J. Shapiro, Transl.). Heinemann Educational, London.
- Habermas J. (1984) *Theory of Communicative Action. vol 1 Reason and the rationalization of society* (T. McCarthy, Transl.). Beacon Press, Boston.
- Habermas J. (1987) *The Theory of Communicative Action. vol 2 Lifeworld and system: a critique of functionalist reason* (T. McCarthy, Transl.). Polity Press, Cambridge.

- Hackman J. R. and Wageman R. (1995) Total Quality Management: Empirical, Conceptual, and Practical Issues. In R.E. Cole and E.R. Scott (eds.) *The Quality Movement Organization Theory* (pp. 23-48). Sage Publications Ltd., London.
- Harré R. and Secord P.F. (1972) *The explanation of social behaviour*. Blackwell, Oxford.
- Harrison S. (2002) New Labour, Modernisation and the Medical Labour Process. *Journal of Social Policy* **31**(3), 465-485.
- Harrison S. (2004) Governing Medicine: Governance, Science and Practice. In A. Gray and S. Harrison (eds.) *Governing Medicine: Theory and Practice* (pp. 180-187). Open University Press, Maidenhead.
- Harrison S. and Ahmad W.I.U. (2000) Medical Autonomy and the UK State 1975 to 2025. *Sociology* **34**(1), 129-146.
- Harrison S. and Dowswell G. (2002) Autonomy and bureaucratic accountability in primary care: what English general practitioners say. *Sociology of Health & Illness* **24**(2), 208-226.
- Harrison S., Dowswell G. and Wright J. (2002a) Practice nurses and clinical guidelines in a changing primary care context: an empirical study. *Journal of Advanced Nursing* **39**(3), 299-307.
- Harrison S., Dowswell G., Wright J. and Russell I. (2003) General practitioners' uptake of clinical practice guidelines: a qualitative study. *Journal of Health Services Research and Policy* **8**(3), 149-153.
- Harrison S. and Gray A. (2003a) Clinical governance - early studies: an introduction. *Clinical Governance* **8**(1), 7-8.
- Harrison S., Hunter D.J., Marnoch G. and Pollitt C. (1992) *Just Managing: Power and Culture in the National Health Service*. Macmillan Press, Basingstoke.
- Harrison S. and Lim J.N.W. (2000a) Clinical governance and primary care in the English National Health Service: some issues of organization and rules. *Critical Public Health* **10**(3), 321-329.

- Harrison S. and Lim J.N.W. (2003b) The Frontier of Control: Doctors and Managers in the NHS 1966 to 1997. *Clinical Governance: An International Journal* **8(1)**, 13-18.
- Harrison S., Moran M. and Wood B. (2002b) Policy emergence and policy convergence: the case of 'scientific-bureaucratic medicine' in the United States and United Kingdom. *British Journal of Politics and International Relations* **4(1)**, 1-24.
- Harrison S. and Pollitt C. (1994) *Controlling Health Professionals. The Future of Work and Organization in the National Health Service*. Open University Press, Buckingham.
- Hartley A.M., Griffiths R.K. and Saunders K.L. (2002) An evaluation of clinical governance in the public health departments of the West Midlands Region. *Journal of Epidemiology and Community Health* **56**, 563-568.
- Harvey G. (1991) An evaluation to approaches of assessing the quality of nursing care using (predetermined) quality assurance tools. *Journal of Advanced Nursing* **16(3)**, 277-286.
- Harvey G. (1999) A nursing perspective on clinical governance: policy, principles and priorities. *Journal of Clinical Excellence* **1**, 167-174.
- Haug M. (1988) A Re-examination of the hypothesis of deprofessionalisation. *The Milbank Quarterly Supplement* **2**, 48-56.
- Hernadi P. (1987) Literary interpretation and the rhetoric of the human sciences. In J.S. Nelson, A. Megill and D.N. McCloskey (eds.) *The rhetoric of the human sciences: language and argument in scholarship and public affairs* (pp. 263-275). University of Wisconsin Press, Madison.
- Hirst P. (2000) Democracy and Governance. In J. Pierre (ed.) *Debating Governance: Authority, Steering and Democracy* (pp. 13-35). Oxford University Press, Oxford.
- Hoggett P. (1991) A New Management in the Public Sector? *Policy and Politics*. **19(4)**, 143-156.
- Hoggett P. (1996) New modes of control in the public service. *Public Administration* **74(1)**, 9-32.

- Hood, C. (1991) A public management for all seasons? *Public Administration* **69**(1), 3-19.
- Hopkinson G.C. (2003) Stories from the Front-line: How they construct the Organization. *Journal of Management Studies* **40**(8), 1943-1969.
- House of Lords and House of Commons (1999) *Health Bill*. The Stationery Office, London.
- Hunt G. (1991) Can Nursing lead care? *Nursing Standard* **5**(25), 18.
- Jacobs K. (2004) Accountability and Clinical Governance in Nursing: a Critical Overview of the Topic. In S. Tilley and R. Watson (eds.) *Accountability in Nursing and Midwifery* (2nd edn.) (pp. 21-37). Blackwell Science Ltd, Oxford.
- Jones J. (2000) *Clinical governance – a nursing perspective: Wisdom Keynote*. The Wisdom Centre. 30 Mar 2005 <<http://www.wisdomnet.co.uk/cgnurse.htm>>.
- Jordens C.F.C. and Little M. (2004) 'In this scenario, I do this for these reasons': narrative, genre and ethical reasoning in the clinic. *Social Science and Medicine* **58**(9), 1635-1645.
- Kanter R.M. (1984) *The change masters: innovation and entrepreneurship in the American corporation*. Simon & Schuster, New York.
- Kelle U. (2001) Sociological Explanations between Micro and Macro and the Integration of Qualitative and Quantitative Methods. *FQS (Forum; Qualitative Social Research)* **2**(1). < <http://www.qualitative-research.net/fqs-texte/1-01/1-01kelle-e.htm> > accessed 29 Sept 2006
- Kerrison S., Packwood T. and Buxton M. (1993) *Medical Audit: taking stock*. Kings Fund, London.
- Kerrison S., Packwood T. and Buxton M. (1994) Monitoring medical audit. In R. Robinson and J. Le Grand (eds.) *Evaluating the NHS reforms* (pp.155-177). Kings Fund Institute, Newbury.
- Kirkpatrick I. and Lucio M.M. (eds.) (1995) *The Politics of Quality in the Public Sector The Management of Change*. Routledge, London.
- Klein R. (1995) *The New Politics of the NHS* (3rd edn.). Longman Group Ltd, Essex.

- Klein R. (1998) Can policy drive quality? *Quality in Health Care* 7(Suppl), S51-53.
- Kooiman J. (ed.) (1993) *Modern Governance: new government-society interactions*. Sage, London.
- Lash S. (1994) Reflexivity and Its Doubles: Structure, Aesthetics, Community. In U. Beck, A. Giddens and S. Lash (1994) *Reflexive Modernization* (pp. 110-173). Polity Press, Cambridge.
- Latham L., Freeman T., Walshe K., Spurgeon P. and Wallace L. (1999) *The early development of clinical governance: a survey of NHS trusts in the West Midlands*. Health Services Management Centre, Birmingham.
- Latimer J. (1995) The nursing process re-examined: enrolment and translation. *Journal of Advanced Nursing* 22(2), 213-220.
- Latour B. (1993) *We Have Never Been Modern* (C. Porter, Transl.). Harvester Wheatsheaf, London.
- Latour B. (1994) On technical mediation: Philosophy, sociology, genealogy. *Common Knowledge* 3(2), 29-64.
- Le Grand J., Mays N. and Mulligan J.A. (eds.) (1998) *Learning From the NHS Internal Market A Review of the Evidence*. Kings Fund, London.
- Leatherman S. and Sutherland K. (1998) Evolving quality in the new NHS: policy, process and pragmatic considerations. *Quality in Health Care* 7 (Suppl) S54-61.
- Lewis F.M. and Batey M.V. (1982) Clarifying Autonomy and Accountability in Nursing Service: Part 2. *Journal of Nursing Administration* 12(10), 10-15.
- Lim J.N.W., Burton T. and Bowens A. (2000) *What elements should be covered in a clinical governance development plan?* Nuffield Portfolio Programme Report 10. University of Leeds, Leeds.
- Lim J.N.W., Ferguson B.A. and Gray A.G. (2001) *Clinical Governance: An Annotated Bibliography*. Nuffield Portfolio Programme Report 14. University of Leeds, Leeds.

- Lincoln Y.S. and Guba E.S. (2000) Paradigmatic Controversies, Contradictions and Emerging Confluences. In N.K. Denzin and Y.S. Lincoln (eds.) *Handbook of Qualitative Research* (2nd edn.) (pp.163-188). Sage Publications Ltd., London.
- Lindkvist L. and Llewellyn S. (2003) Accountability, responsibility and organisation. *Scandinavian Journal of Management* **19**(2), 251-273.
- Lipsky M. (1980) *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. Russell Sage Foundation, New York.
- Llewellyn S. (1998) Boundary work: costing and caring in the Social Services. *Accounting, Organizations and Society* **23**(1), 23-48.
- Llewellyn S. (1999) Narratives in accounting and management research. *Accounting, Auditing & Accountability Journal* **12**(2), 220-236.
- Llewellyn S. (2001) 'Two-way windows': clinicians as medical managers. *Organization Studies* **22**(4), 593-624.
- Llewellyn S. (2003) What counts as "theory" in qualitative management and accounting research? Introducing five levels of theorizing. *Accounting, Auditing & Accountability Journal* **16**(4), 662-708.
- Lugon M. and Secker-Walker J. (eds.) (1999) *Clinical Governance Making It Happen*. Royal Society of Medicine Press Ltd, London.
- Lyotard J.F. (1984) *The postmodern condition: A report on knowledge* (G. Bennington and B. Massumi, Transl.). Manchester University Press, Manchester.
- MacIntyre A. (1985) *After Virtue: a study in moral theory* (2nd edn.). Duckworth, London.
- MacIntyre A. (1988) *Whose Justice? Which Rationality?* University of Notre Dame Press, Notre Dame.
- Maile S. and Hoggett P. (2001) Best Value and the politics of pragmatism. *Policy and Politics* **29**(4), 509-519.
- Mander R. (2004) Where Does the Buck Stop? Accountability in Midwifery. In S. Tilley and R. Watson (eds.) *Accountability in Nursing and Midwifery* (2nd edn.) (pp. 132-142). Blackwell Science Ltd, Oxford.

- March J.G. and Olsen J.P. (1989) *Rediscovering Institutions The Organizational Basis of Politics*. The Free Press, New York.
- Marnoch G., McKee L. and Dinnie N. (2000) Between organizations and institutions. Legitimacy and medical managers. *Public Administration* **78**(4), 967-987.
- Marsh D. and Rhodes R.A.W. (eds.) (1992) *Policy Networks in British Government*. Clarendon Press, Oxford.
- Maxwell R. (1984) Quality assessment in health. *British Medical Journal* **288**, 1470-1472.
- Maynard A. (1999) Clinical governance - an economic perspective. *British Journal of Clinical Governance* **4**(1), 4-6.
- Maynard A. (1999a) Clinical governance: the unavoidable economic challenges. *NTRResearch* **4**(3), 189-191.
- McIntosh J. (2000) The invisible work of the district nursing team: methodological problems associated with exploring skills. *Primary Health Care Research and Development* **1**(2), 103-112.
- McIntosh J., Moriarty D., Lugton J. and Carney O. (2000) Evolutionary change in the use of skills within the district nursing team: a study in two Health Board areas in Scotland. *Journal of Advanced Nursing* **32**(4) 783-790.
- McMahon A. (2003) Promoting Excellence: A draft RCN position statement. *Nursing Standard* **17**, 32-41.
- Mead P. (2000) Clinical guidelines: promoting clinical effectiveness or a professional minefield? *Journal of Advanced Nursing* **31**, 110-116.
- Melia K. (1995) Accountability – the ethical dimension. In R. Watson (ed.) *Accountability in Nursing Practice* (pp.177-180). Chapman and Hall, London.
- Meyer J.W. and Rowan B. (1977) Institutionalized Organizations: formal structure as myth and ceremony. *The American Journal of Sociology* **83**(2), 340-363.
- Milewa T., Dowswell G. and Harrison S. (2002) Partnerships, Power and the "New" Politics of Community Participation in British Health Care. *Social Policy and Administration* **36**(7), 796-809.

Miller P. and Rose N. (1990) Governing economic life. *Economy and Society* **19**(1), 1-31.

Ministry of Health and Scottish Home and Health Department. (1966) (*Report of the Committee on senior nursing staff structure*. (Chairman: Brian Salmon). HMSO, London.

Mishler E.G. (1986) *Research Interviewing. Context and Narrative*. Harvard University Press, Cambridge, MA.

Moran-Ellis J., Alexander V., Cronin A., Dickinson M., Fielding J., Sleney J. and Thomas H. (2006) Triangulation and integration: processes, claims and implications. *Qualitative Research*. **6**(1), 45-59.

Morgan G. (1986) *Images of Organizations*. Sage Publications, London.

Munro R. (1996) Alignment and Identity Work, the Study of Accounts and Accountability. In R. Munro and J. Mouritson (eds.) *Accountability, Power, Ethos and the Technologies of Managing* (pp. 1-19). International Thomson Business Press, London.

Munro R. and Mouritson J. (1996) *Accountability, Power, Ethos and the Technologies of Managing*. International Thomson Business Press, London.

National Audit Office. (2003) *Achieving Improvements through Clinical Governance A Progress Report on Implementation by NHS Trusts*. Report by the Comptroller and Auditor General. HC 1055 Session 2002-2003. The Stationery Office, London.

Newman J. (2001) *Modernising Governance New Labour, Policy and Society*. Sage Publications, London.

NHS Executive (1999) *Making a Difference: a strategy for nursing, midwifery and health visiting*. The Stationery Office, London.

NHS Management Executive Value for Money Unit (1993) *The Nursing Skill Mix in the District Nursing Service*. HMSO, London

NHS Quality Improvement Scotland (2003) *National Overview Safe and Effective Patient Care Generic Clinical Governance Standards*. NHS Quality Improvement Scotland, Edinburgh.

- Nursing and Midwifery Council (2002) *The Code of Professional Conduct*. NMC, London.
- Nursing and Midwifery Council (2004) *The NMC code of professional conduct: standards for conduct, performance and ethics*. NMC, London.
- Nursing and Midwifery Council (2005) *Press Release: Nursing Regulator Announces Shake-Up of Conduct Code*. NMC, London.
- OED Online (1989) 30 Aug 2005 <<http://www.oed.com>>
- Orum A.M., Feagin J.R. and Sjoberg G. (1991) Introduction: The nature of the case study. In J.R. Feagin, A.M. Orum and G. Sjoberg (eds.) *A case for the case study* (pp. 1-26). The University of North Carolina Press, Chapel Hill, NC.
- Osborne D. and Gaebler T. (1992) *Reinventing Government*. Addison-Wesley, Reading, MA.
- Overington M.A. (1977) Kenneth Burke and the methods of dramatism. *Theory and Society* 4 (Spring), 131-156.
- Overington M.A. (1977a) Kenneth Burke as social theorist. *Sociological Inquiry* 47(2), 133-141.
- Owens P., Carrier J. and Horder J. (eds.) (1995) *Interprofessional Issues in Community and Primary Health Care*. Macmillan Press Ltd., Hampshire.
- Owens P. and Glennerster H. (1990) *Nursing in Conflict*. Macmillan Education Ltd, London.
- Øvretveit J. (1992) *Health Service Quality*. Blackwell Scientific Press, Oxford.
- Packwood T., Buxton M. and Keen J. (1990) Resource management in the National Health Service: a first case history. *Policy and Politics* 18(4), 245-255.
- Packwood T., Keen J. and Buxton M. (1991) *Hospitals in Transition: the resource management experience*. Open University Press, Milton Keynes.
- Palmer R.H., Donabedian A. and Povar G.J. (eds.) (1991) *Striving for Quality in Health Care: An Inquiry Into Policy and Practice*. Health Administration Press, Michigan.

- Pattison S. (2001) Are Nursing Codes of Practice Ethical? *Nursing Ethics* 8(1), 5-18.
- Peters B.G. (2000) Governance and Comparative Politics. In J. Pierre (ed.) *Debating Governance: Authority, Steering and Democracy* (pp. 36-53). Oxford University Press, Oxford.
- Peters B.G. and Savoie D. (eds.) (1998) *Taking Stock: Assessing Public Sector Reforms*. McGill-Queen's University Press, Montreal and Kinston.
- Peters T.J. and Waterman R.H. (1982) *In Search of Excellence*. Harper and Row, New York.
- Pettigrew A., Ferlie E.B. and McKee L. (1992) *Shaping Strategic Change: Making Change in Large Organizations - The Case of the National Health Service*. Sage Publications, London.
- Pierre J. (ed.) (2000) *Debating Governance: Authority, Steering and Democracy*. Oxford University Press, Oxford.
- Pierre J. and Peters B.G. (2000) *Governance, Politics and the State*. St Martin's Press, New York.
- Polkinghorne D.E. (1988) *Narrative Knowing and the Human Sciences*. State University of New York Press, New York.
- Pollitt C. (1993) *Managerialism and the Public Services Cuts of Cultural Change in the 1990's?* Blackwell Publishers, Oxford.
- Pollitt C., Birchall J. and Putman K. (1998) *Decentralising Public Service Management*. Palgrave Macmillan Press Ltd, Basingstoke.
- Pollitt C., Harrison S., Hunter D.J. and Marnoch G. (1990) No Hiding Place: On the Discomforts of Researching the Contemporary Policy Process. *Journal of Social Policy* 19(2), 169-190.
- Pollock L. (2004) Accountability and Clinical Governance in Nursing: a Manager's Perspective. In S. Tilley and R. Watson (eds.) *Accountability in Nursing and Midwifery* (2nd edn.) (pp. 87-98). Blackwell Science Ltd, Oxford.
- Potter J. (1996) *Representing Reality Discourse, Rhetoric and Social Construction*. Sage Publications Ltd, London.

regulatory systems of the health professions (Donaldson and Gray, 1998). It is to the second of these aspects that the next section turns, with a consideration of the development of the quality agenda.

1.2.2 Clinical governance and quality

It is stated that the implementation of clinical governance is based on a “new” definition of quality described as “doing the right things, at the right time, for the right people, and doing them right - first time” (DoH, 1997, para. 3.2) a point also reiterated by Donaldson and Gray (1998). However, Klein comments on the collective amnesia associated with this “new” approach in the light of the quality activity in the NHS over the last two decades (Klein, 1998). This comment is particularly pertinent given the long pedigree of use in private sector of this “right - first time” definition, notably in association with the development of quality control systems (Price, 1984).

This emphasis on the management of quality processes has been a feature of earlier government reforms, being described as a means of incorporating health professionals into the management process (Harrison and Pollitt, 1994; Harrison, 2002), and also as “inextricably linked with issues of managerial and clinical control and power” (Sutherland and Dawson, 1998, S.16). Despite the widespread interest in the management of quality across the private and public sectors remarkably little research has been completed (Cole and Scott, 2000), although there has been some evaluation of specific projects in the NHS (CEPP, 1991; Harvey, 1991). It is proposed in the public administration and management literature that these developments are concerned with organisational control (Hoggett, 1996; Reed, 1996). Hoggett suggesting that the quality systems currently in use in the public sector are based on either a rational strategy or normative model. The rational strategy is characterised by detailed performance specifications, routine monitoring and a “deeply mechanistic” methodology (Hoggett, 1996, p. 23), with the examples given of the British Standards approach and Patient’s Charter. By contrast, normative models are said to emphasise trust, shared values, leadership and development of the organisational culture, with the primary example of this being the TQM approach.

- Potter J. and Wetherell M. (1987) *Discourse and Social Psychology*. Sage, London.
- Power M. (1997) *The Audit Society: Rituals of Verification*. Oxford University Press, Oxford.
- Price F. (1984) *Right First Time: Using Quality Control for Profit*. Gower Publishing Company Limited, Aldershot.
- Rafferty A.M. (1992) Nursing policy and the nationalisation of nursing: the representation of 'crisis' and the crisis of representation. In J. Robinson, A. Gray and R. Elkan (eds.) *Policy Issues in Nursing* (pp. 68-83). Open University Press, Buckingham.
- Reed H. (1942) Naming of Parts. *New Statesman and Nation* **598**, 92.
- Reed M.I. (1996) Expert power and control in late modernity: an empirical review and theoretical synthesis. *Organisation Studies* **17**(4), 573-597.
- Rhodes R.A.W. (1997) *Understanding Governance Policy Networks, Governance, Reflexivity and Accountability*. Open University Press, Buckingham.
- Rhodes R.A.W. (2000) Governance and Public Administration. In J. Pierre (ed.) *Debating Governance: Authority, Steering and Democracy* (pp. 54-90). Oxford University Press, Oxford.
- Riessman C.K. (1993) *Narrative Analysis*. Sage Publications, London.
- Ring N. (2002) *The RCGP Quality Practice Award for Practice Teams: a practical guide for nurses and midwives working towards the Quality Practice Award*. NHS Scotland, Edinburgh
- Roberts J. (1991) The Possibilities of Accountability. *Accounting, Organizations and Society* **16**(4), 355-368.
- Roberts J. (1996) From Discipline to Dialogue: Individualizing and Socializing Forms of Accountability. In R. Munro and J. Mouritson (eds.) *Accountability, Power, Ethos and the Technologies of Managing* (pp. 40-61). International Thomson Business Press, London.
- Robinson J., Gray A. and Elkan R. (1992) *Policy Issues in Nursing*. Open University Press, Milton Keynes.

- Robinson R. and Le Grand J. (1994) *Evaluating the NHS reforms*. Kings Fund Institute, Newbury.
- Rogers E.M. (1983) *Diffusion of Innovations*. Collier Macmillan, London.
- Rolfe G. (2000) *Research, Truth and Authority: Postmodern Perspectives on Nursing*. Macmillan Press Ltd, London.
- Rorty R. (1979) *Philosophy and the Mirror of Nature*. Princeton University Press, Princeton, New Jersey.
- Rorty R. (1989) *Contingency, Irony, and Solidarity*. Cambridge University Press, Cambridge.
- Rose N. (1989) *Governing the Soul: The Shaping of the Private Self*. Free Association Books, London.
- Rose N. (1996) Identity, genealogy, history In S. Hall and P. Du Gay (ed.) *Questions of cultural identity*. (pp. 128-150) Sage Publications, London.
- Rose N. and Miller P. (1992) Political power beyond the state: problematics of governmentality. *British Journal of Sociology* **43**(2), 172-205.
- Rosen R. (2000) Improving quality in the changing world of primary care. *British Medical Journal* **321**, 551-554.
- Rosenau J.N. and Czempiel E.O. (1992) *Governance Without Government: Order and Change in World Politics*. Cambridge University Press, Cambridge.
- Royal College of General Practitioners (Scotland) (2000) *RCGP Quality Practice Award: the application, process and criteria and user's guide (version 5)*. RCGP(S), Edinburgh.
- Royal College of General Practitioners (Scotland) (2000a) *Practice Accreditation*. RCGP(S), Edinburgh.
- Royal College of Nursing (1981) *Towards Standards*. RCN, London.
- Royal College of Nursing (1990) *Dynamic Standard Setting System*. Royal College of Nursing, London.

- Royal College of Nursing (1998) *Guidance for Nurses on Clinical Governance*. RCN, London.
- Royal College of Nursing (2000) *Clinical Governance: how nurses can get involved*. Royal College of Nursing, London.
- Salter B. (1998) *The Politics of Change in the Health Service*. MacMillan Press Ltd, Basingstoke.
- Savage J. and Moore L. (2004) *Interpreting accountability: An ethnographic study of practice nurses, accountability and multidisciplinary team decision-making in the context of clinical governance*. Royal College of Nursing, London.
- Sally G. and Donaldson L. (1998) Clinical governance and the drive for quality improvement in the new NHS in England. *British Medical Journal* **317**, 61-65.
- Schön D.A. (1983) *The Reflective Practitioner*. Basic Books, New York.
- Schön D.A. (1987) *Educating the Reflective Practitioner*. Jossey-Bass, San Francisco.
- Schutz A. (1967) *The phenomenology of the social world* (G. Walsh and F. Lehnert Transl.). Northwestern University Press, Evanston IL.
- Schwandt T.A. (2000) Three epistemological stances for qualitative inquiry. Interpretivism, Hermeneutics, and Social Constructionism. In N.K. Denzin and Y.S. Lincoln (eds.) *Handbook of Qualitative Research* (2nd edn.) (pp. 189-213). Sage Publications Ltd., London.
- Schwandt T.A. (2005) The Centrality of Practice to Evaluation. *American Journal of Evaluation* **26**(1), 95-105.
- Scott I. (1999) Clinical governance: An opportunity for nurses to influence the future of healthcare development. *NTRResearch* **4**(3), 170-176.
- Scott W.R. (1995) *Institutions and Organizations*. Sage Publications, London.
- Scottish Executive Health Department (2000) *Clinical Governance: MEL* (2000) 29. Edinburgh.

- Scottish Executive Health Department (2000a) *Our National Health: a plan for action, a plan for change*. The Stationery Office, Edinburgh.
- Scottish Executive Health Department (2000b) *Community Care: a joint future*. The Stationery Office, Edinburgh.
- Scottish Executive Health Department (2001) *Clinical Governance Arrangements*. HDL (2001)74. Edinburgh.
- Scottish Executive Health Department (2001a) *Nursing for Health: a review of the contribution of nurses, midwives and health visitors to improving the public health in Scotland*. The Stationery Office, Edinburgh.
- Scottish Executive Health Department (2001b) *Caring for Scotland: The Strategy for Nursing and Midwifery in Scotland*. The Stationery Office, Edinburgh.
- Scottish Office Department of Health (1997) *Designed to Care: Renewing the National Health Service in Scotland*. Cm 3811, The Stationery Office, Edinburgh.
- Scottish Office Department of Health (1998) *Guidance on clinical governance: MEL (1998) 75*. Edinburgh.
- Scottish Office Department of Health (1998a) *Modernising Community Care: an action plan*. The Stationery Office, Edinburgh.
- Scottish Office Department of Health (1998b) *Acute Services Review*. The Stationery Office, The Stationery Office, Edinburgh.
- Secretary of State for Health (1990) *National Health Service and Community Care Act*. HMSO, London.
- Sheaff R., Rogers A., Pickard S., Marshall M., Campbell S., Sibbald, S., Halliwell S. and Roland M. (2003) A subtle governance: 'soft' medical leadership in English primary care. *Sociology of Health and Illness* **25(5)**, 408-428.
- Shih F.J. (1998) Triangulation in nursing research: issues of conceptual clarity and purpose. *Journal of Advanced Nursing* **28(3)**, 631-641.
- Signorile V. (1989) Ratios and Causes: The Pentad As an Etiological Scheme in Sociological Explanation. In H.W. Simons and T. Melia (eds.) *The Legacy of Kenneth Burke* (pp. 74-98). The University of Wisconsin Press, Madison.

- Simons H.W. (1989) Introduction: Kenneth Burke and the rhetoric of the human sciences. In H.W. Simons and T. Melia (eds.) *The Legacy of Kenneth Burke* (pp. 3-27). The University of Wisconsin Press, Madison.
- Simons H.W. and Melia T. (eds.) (1989) *The Legacy of Kenneth Burke*. The University of Wisconsin Press, Madison.
- Sinclair A. (1995) The chameleon of accountability: forms and discourses. *Accounting, Organizations and Society* **20**(2-3), 219-237.
- Sines D., Appleby F. and Raymond E. (2001) *Community Health Care Nursing* (2nd edn.). Blackwell Science Ltd., Oxford.
- Stake R. (2000) Case studies In N.K Denzin. and Y.S Lincoln (eds.) *Handbook of Qualitative Research* (2nd edn.) (pp. 435-454). Sage Publications Ltd., London.
- Strong P. and Robinson J. (1990) *The NHS Under New Management*. Open University Press, Milton Keynes.
- Suchman M.C. (1995) Managing Legitimacy: Strategic and Institutional Approaches. *Academy of Management Review* **20**(3), 571-610.
- Sutherland K. and Dawson S. (1998) Power and quality improvement in the new NHS: the roles of doctors and managers. *Quality in Health Care* **7** (Suppl), S16-23.
- Swage T. (2000) *Clinical Governance in health care practice*. Butterworth-Heinemann, Oxford.
- Symonds A. (1998) The social construction and the reality of community care. In A. Symonds and A. Kelly (eds.) *The Social Construction of Community Care* (pp.7-31). Macmillan Press Limited, London.
- Tait A. (2004) Clinical governance in primary care: a literature review. *Journal of Clinical Nursing* **13**(6), 723-730.
- Taylor D. (1996) Quality and professionalism in health care: a review of current initiatives in the NHS. *British Medical Journal* **312**, 626-629.
- The NHS Confederation (2003) Governing the NHS. *The NHS Confederation briefing* **9**, 1-6.

- Tilley S. (1995) Accounts accounting and accountability in psychiatric nursing. In R. Watson (ed.) *Accountability in Nursing Practice* (pp. 107-130). Chapman & Hall, London.
- Tilley S. (ed.) (1997) *The mental health nurse: views of practice and education*. Blackwell Science Oxford.
- Tilley S. (2004) Clinical Governance, Accountability and Mental Health Nursing: an Emergent Story. In S. Tilley and R. Watson (eds.) *Accountability in Nursing and Midwifery* (2nd edn.) (pp. 157-169). Blackwell Science Ltd, Oxford.
- Tilley S. and Watson R. (eds.) (2004) *Accountability in Nursing and Midwifery* (2nd edn.). Blackwell Science Ltd, Oxford.
- Tingle J. (2002) Introduction of a new Nursing Code of Professional Conduct. *British Journal of Nursing* **11**(10), 665.
- Tingle J. (2004) The Legal Accountability of the Nurse. In S. Tilley and R. Watson (eds.) *Accountability in Nursing and Midwifery* (2nd edn.) (pp. 47-63). Blackwell Science Ltd, Oxford.
- Traynor M. (1994) The views and values of community nurses and their managers: research in progress – one person's pain, another person's vision. *Journal of Advanced Nursing* **20**(1), 101-109.
- Traynor M. (1996) A literary approach to managerial discourse after the NHS reforms. *Sociology of Health and Illness* **18**(3), 315-340.
- Traynor M. (1999) *Managerialism and Nursing: beyond oppression and profession*. Routledge, London.
- Tschudin V. (1992) *Ethics in Nursing: the caring relationship* (2nd edn.). Butterworth-Heinemann, Oxford.
- Tschudin V. (2003) *Ethics in Nursing: the caring relationship* (3rd edn.). Butterworth-Heinemann, Oxford
- Tschudin V. and Hunt G. (1999) Editorial. *Nursing Ethics* **6**(1), 1-2.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) *Code of Professional Conduct Professional Conduct for Nurses, Midwives and Health Visitors* (3rd edn.). UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Making the connection - professional self-regulation and clinical governance*. UKCC, London.

Walby S., Greenwell J., Mackay L. and Soothill K. (1994) *Medicine and Nursing. Professions in a Changing Health Service*. Sage Publications, London.

Walker K. (2003) Why evidence-based practice now? A polemic. *Nursing Inquiry* 10(3), 145-155.

Walker R. and Monin N. (2001) The purpose of the picnic: using Burke's dramatic pentad to analyse a company event. *Journal of Organizational Change Management* 14(3), 266-279.

Walshe K. (2000) *Clinical Governance: a review of the evidence*. School of Public Policy, University of Birmingham, Birmingham.

Walshe K., Cortvriend P. and Mahon A. (2003) *All change? Implementing clinical governance in NHS trusts in England*. Manchester Centre for Health Care Management, University of Manchester.

Walshe K., Freeman T., Latham L., Wallace L. and Spurgeon P. (2000) *Clinical governance: from policy to practice*. Health Services Management Centre, University of Birmingham.

Warner R.S. (1991) Oenology: The making of new wine. In J.R. Feagin, A.M. Orum and G. Sjoberg (eds.) *A case for the case study* (pp. 174-199). University of North Carolina Press, Chapel Hill, NC.

Watson R. (ed.) (1995) *Accountability in Nursing Practice*. Chapman and Hall, London.

Watson R. (1995a) Introduction: accountability in nursing. In R. Watson (ed.) *Accountability in Nursing Practice* (pp. 1-17). Chapman & Hall, London.

- Watson R. (2004) Accountability and Clinical Governance. In S. Tilley and R. Watson (eds.) *Accountability in Nursing and Midwifery* (2nd edn.) (pp. 38-46). Blackwell Science Ltd, Oxford.
- Weber M. (1949) *The Methodology of the Social Sciences* (E. A. Shils and H. A. Finch, Transl.). Free Press, Glencoe, IL.
- Wess R. (1996) *Kenneth Burke, Rhetoric, Subjectivity, Postmodernism*. Cambridge University Press, Cambridge.
- West E. and Scott C. (2000) Nursing in the public sphere: breaching the boundary between research and policy. *Journal of Advanced Nursing* **32(4)**, 817-824.
- Willmott H. (1996) Thinking Accountability: Accounting for the Disciplined Production of Self. In R. Munro and J. Mouritson (eds.) *Accountability, Power, Ethos and the Technologies of Managing* (pp. 23-39). International Thomson Business Press, London.
- World Health Organization (1994) *Report of the WHO working group on Quality Assurance*. 1-29, WHO, Geneva.

Respondent	Age range	Educational, professional and team factors
District Nurse 1 Trust 1	40-49	Registered nurse, with a postgraduate community nursing qualification and educated to degree level. The district nurse was a caseload holder and team leader of a nursing team working in a semi-rural location.
District Nurse 2 Trust 1	30-39	Registered nurse with a postgraduate community nursing qualification. The district nurse was a caseload holder and team leader of a nursing team working in a large conurbation.
District Nurse 3 Trust 1	40-49	Registered nurse with a postgraduate community nursing qualification. The district nurse was a caseload holder and worked as a member of a team located in an inner city setting.
District Nurse 4 Trust 1	40-49	Registered nurse with a postgraduate community nursing qualification and educated to degree level. The district nurse was a caseload holder and team leader of a nursing team working in a small town.
District Nurse 1 Trust 2	50-59	Registered nurse and postgraduate community nursing qualification. The district nurse was a caseload holder and worked as a member of a team located in an inner city setting.
District Nurse 2 Trust 2	30-39	Registered nurse, postgraduate community nursing qualification. The district nurse was a caseload holder and team leader of a team located in an inner city setting.
District Nurse 3 Trust 2	50-59	Registered nurse, postgraduate community nursing qualification. The district nurse was a caseload holder and team leader of a team working in a rural setting.
District Nurse 4 Trust 2	30-39	Registered nurse with a post graduate community nursing qualification and educated to degree level. The district nurse was employed as caseload holder and team leader of a team located in a semi-rural setting.
Staff Nurse 1 Trust 1	30-39	Registered nurse, educated to degree level and a member of a nursing team located in a large conurbation.

Respondent	Age range	Educational, professional and team factors
Staff Nurse 1 Trust 2	20-29	Registered nurse, educated to degree level, and a member of a nursing team located in an inner city setting.
Staff Nurse 2 Trust 2	40-49	Registered nurse, educated to degree level and a member of a nursing team located in a semi-rural setting.
Manager 1 Trust 1	40-49	Registered nurse with a postgraduate community nursing qualification and educated to degree level. The manager held responsibility for a community setting located in a major conurbation.
Manager 2 Trust 1	40-49	Registered nurse with a postgraduate community nursing qualification and educated to degree level. The manager held responsibility for community teams in a semi-rural setting.
Manager 3 Trust 1	50-59	Registered nurse with a postgraduate community nursing qualification. The manager was responsible for community teams in a semi-rural setting.
Manager 1 Trust 2	40-49	Registered nurse and educated to degree level with management qualifications. The manager held responsibility for community teams in an inner city setting.
Manager 2 Trust 2	50-59	Registered nurse with a postgraduate community nursing qualification. The manager was responsible for community teams in a rural setting.
Manager 3 Trust 2	40-49	Registered nurse with a postgraduate community nursing qualification and management qualifications. The manager held line management responsibility for community teams in a semi-rural setting.

Notably, the concept of trust features prominently in the later development of clinical governance (Davies and Mannion, 1999; Watson, 2004).

The range of quality projects implemented following these reforms has been identified by Taylor (1996), with development advancing on several fronts, and characteristically following occupational lines (Harrison and Pollitt, 1994; Pollitt et al., 1998). There was however little evidence of integration between the managerial and professional strands, and the concept of quality is described as becoming “increasingly promiscuous” and contested (Pollitt 1993, p. 183).

The health professions have a long history of involvement in quality activities, notably the nursing profession which has been involved with systems as divergent as standard setting and accreditation (RCN, 1981, 1990; Ellis and Whittington, 1993). A survey conducted in 1989 identified 1,478 quality initiatives underway in England and Wales, the majority of which had some form of nursing involvement (Harrison and Pollitt, 1994). Interestingly, despite this tradition of involvement, there has been little critical analysis of the agenda by members of the nursing profession with much of the literature describing current initiatives or concerned with promoting nursing involvement in these developments (RCN, 1998, 2000; Scott, 1999; Currie et al., 2003). An examination of medical and nursing audit however found that the two professions vary in their approach, with the medical profession conceptualising the initiative as a peer review, educational and confidential process, with managers largely excluded from the activities. The situation with nursing audit was different, with the nursing profession found to concentrate less on the detailed rules of audit procedure than their medical colleagues and more concerned with the processes of conducting audit (Harrison and Pollitt, 1994).

Another aspect of nursing involvement which has been identified followed from the appointment of nurse managers to quality management posts. This has subsequently been described as having created an accidental lobby for quality as:

Respondent	Age range	Educational, professional and team factors
Manager 4 Trust 2	30-39	Registered nurse with a postgraduate community nursing qualification and educated to degree level. The manager held responsibility for community teams in an inner city location.
Support Nurse Trust 1	30-39	Registered nurse with a nurse teaching qualification and educated to degree level. The support nurse provided training and development for nursing staff related to professional and organisational development.
Support Nurse Trust 2	40-49	Registered nurse with an HND and management qualifications. The support nurse provided specialist advice and assistance to community nursing staff related to clinical effectiveness and clinical audit projects.

Jobs had to be found for dispossessed nurse managers and quite a few of them re-emerged in charge of quality assurance (Klein, 1995, p. 151).

Harrison and Pollitt (1994) suggest that this had profound implications for the nursing profession, with nursing audit led in some instances by nurse managers who also held responsibility for service quality. This, it is suggested, caused the potential for an overlap between service and professional issues, allowing nursing care to become visible and transparent to managers with:

little sign of effective resistance to the continuing systematization of nursing. The nursing process is becoming steadily more transparent to and manipulable by managers (Harrison and Pollitt, 1994, p. 111).

The final element of the quality agenda was addressed by management, with the twofold aim of creating a corporate approach to quality and measuring user satisfaction with services provided. Typically projects included TQM, QA and CQI, and the use of satisfaction surveys (Øvretveit, 1992; Ellis and Whittington, 1993; Harrison and Pollitt, 1994; Taylor, 1996).

1.2.3 Clinical governance and accountability

The final concept considered in this overview is the central one of accountability. Dewar (1999, 2000) provides a useful overview of clinical governance and accountability, describing accountability as the backbone and driver of the clinical governance process. This backbone is created from two systems. Firstly the organisational structure enabling hierarchical accountability from the Chief Executive to the government and public; and, secondly, those organisations associated with the regulation of the health professions (Dewar, 2000). However, a distinction is drawn between these formal and structural approaches to accountability and the creation of processes which act as a basis for change and improvement. Dewar states that the definition of clinical governance has been left incomplete with health professionals having “embarked on a debate to define their own systems of clinical governance in their own way” (Dewar, 2000, p. 31). Thus the functioning of the accountability backbone depends on negotiated processes between the health

professions. These processes will be influenced by local circumstances where “action is more often a matter of local agreement rather than national edict” (Dewar, 2000, p. 33). Dewar identifies interprofessional collaboration as pivotal to the progress of the agenda. Fundamental to success is that all staff groups are enabled to influence outcomes, regardless of their explicit or implicit power base in the organisation. This form of horizontal accountability places the emphasis on teamwork, collaboration and discussion as well as the development of a structure for clinical governance.

Various models have been proposed as a means of involving health professionals in clinical governance based on trust (Davies and Mannion, 1999), formal performance measures (Bloor and Maynard, 1998) and developing self governance (Degeling, Maxwell and Iedema, 2004a). The development of trust is associated with use of principal-agent relationships, with the role of the principal held by service managers and that of the agent by the health professionals. The authors argue for the importance of creating a balance between trusting clinical professionals and developing control systems (Davies and Mannion, 1999). Contrasting with this, Bloor and Maynard (1998) describe clinical governance as being concerned with the delivery of equitable and cost effective care, recommending the use of cost effectiveness information alongside that related to clinical effectiveness, and that clinical care follows scientifically valid guidelines. Finally, Degeling, Maxwell and Iedema (2004a) propose the use of multi-disciplinary pathways as a model for the development of clinical governance, with clinical teams invited to describe, define and validate processes of patient care. The authors suggest that this process, whilst recognising the centrality of clinicians to the care process, will disseminate information and prevent the monopoly of power and control. Degeling, Maxwell and Iedema argue that this is not a Taylorization of work, as has been proposed by Harrison (2002), linking it instead with both Habermas’ (1984, 1987) ideal speech types and Rose’s (1996) use of governmentality to “enfold the authority of a system of clinical *self*-governance ‘into the soul’” (Degeling, Maxwell and Iedema, 2004a, p. 179).

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From this review it is evident that although clinical governance is at an early stage of theoretical development, the initiative is building on earlier reforms. The next section turns to empirical studies conducted on the management reforms, considering first those completed on the pre-clinical governance reforms and secondly, examining studies of the clinical governance reforms.

1.3 Empirical research

Empirical research of the NHS management reforms presents a fragmented picture, with Flynn (2002) observing that the development of clinical governance has been under theorised. The literature survey identified a number of empirical studies representing a range of perspectives, including those concerned with the examination of the impact of the reforms at regional, district and unit levels (Strong and Robinson, 1990; Harrison et al., 1992; Pettigrew et al., 1992), and mapping the increase of managerial power and simultaneous loss of professional power and autonomy (Harrison et al., 1992; Harrison and Dowswell, 2002; Sheaff et al., 2003). Research focused on the nursing profession is less well represented, although it is interesting to note the innovative methods used in those studies focused wholly, or largely, on the nursing profession (Strong and Robinson, 1990; Traynor, 1996, 1999).

1.3.1 Management reforms

Amongst one of the earliest studies of the management reforms was the examination by Strong and Robinson (1990), which originated in concerns about the impact of the management reforms on the nursing profession and was intended to show how people try to “cope with, understand and implement change” (Strong and Robinson, 1990, p. xiii). The scope of the original study had been the nursing profession, but this was subsequently extended to include all staff groups. An intensive study of seven Health Authority districts in England provided the research setting, with the researchers attending meetings and conducting 140 interviews with staff including managers, nurse managers and medical staff. The research approach was termed “policy ethnography” (Strong and Robinson, 1990, p. 8), a feature of this method being the use of a dialogical approach during the interviews, and the rationale

explained by the description of the respondents as experts in their field. Consequently, the researchers treated the interaction between interviewer and interviewee as a shared attempt to understand the complexities of the reforms, with detailed accounts of the impact of these developments being elicited.

The data collected covered a breadth of aspects associated with the reforms, which were presented to reflect aspects of the general management process including the management of the clinical trades, new model management, district level and finally an assessment of general management. This enabled the presentation of a comprehensive picture of these reforms from the district level of the NHS. The findings were presented as extended narratives constructing a story which “has several acts and each tries to balance or complement those that have gone before; each part must be interpreted in the light of the whole” (Strong and Robinson, 1990, p. 32).

Included within this story were nursing perspectives of the reform and the view of the nursing profession held by managerial and medical respondents. These views indicated the changing role of nurse managers, the problems nurses were experiencing resultant from these reforms and the position of the nursing profession in the new management structure. The general management arrangements were identified as being based on principles of systematic monitoring and a single line of command, although the managers were identified as having failed to reduce the power of the medical profession. A contrasting and stark portrayal of the position of the nursing profession emerged from the in-depth analysis. Accordingly, managers were presented as viewing the nursing profession as weak and suffering from the constraints of professional ignorance and those imposed by the nursing hierarchy, with the managers side-stepping senior nurses and seeking professional advice from other staff. Although the researchers acknowledged that developments in professional education were addressing some of these factors, overall the existence of a rigid hierarchical structure was depicted as preventing the development of the profession.

An important aspect of this research was the analysis of the management of quality and of costs under the new arrangements. An inextricable linkage between these two aspects was identified, with the management of quality being represented by the research findings as a cost cutting exercise. The role of nurse managers who had been appointed to quality management positions in the new organisations was explored, with Strong and Robinson (1990) questioning if the nurse managers had the necessary knowledge and support to sustain these roles, particularly given that general managers considered quality of care as being of low priority compared with the requirement to control costs. Knowledge and information provide an important sub-text in this discussion, especially in terms of identifying the source of the power of the medical profession which “rested crucially on their monopoly of medical knowledge” (Strong and Robinson, 1990, p. 42). This portrayal is in stark contrast to that of the nurses who are described as having “bio-medical ignorance” (1990, p. 42). Strong and Robinson ask:

Could the responsibility for service quality really be given to those who were busy on other things, who had no support staff, whose knowledge was focused on just one corner of the service, whose competence was in question or who had little or no education or research experience? (Strong and Robinson, 1990, p. 182).

The research presented a bleak picture of nursing, with general managers perceiving some nurse managers as unable to perform their management roles or of providing the managers with the professional advice they required. Overall managers were depicted as viewing the nursing profession as an easy means of making efficiency savings, consequent to which the vexed question of nursing manpower levels received little investment in terms of research. However, in those cases where research and knowledge was required to support a nursing function, this was found to be viewed as low priority compared with controlling costs. Accordingly, the researchers concluded that the nursing profession:

was trapped deep within a black hole. Those on the outside could not see in. Those on the inside could not see out. The largest and most expensive part of the NHS remained

unmeasured, unmonitored, ignored (Strong and Robinson, 1999, p. 177).

This study presents a comprehensive account of these earlier reforms and the impact on the senior level of the nursing profession through the eliciting and presenting of a complex array of data, identifying the factors influencing the nursing role in the reforms and the complexity of reform processes at organisational level. The following descriptive study was also located primarily at organisational level although in this instance the study was focused primarily on the nursing profession, with the respondents extended to include managers and ward sisters.

The longitudinal study conducted by Glennerster et al. (1986), Glennerster and Owens (1987) and Owens and Glennerster (1990), examined the impact of the Griffiths reforms on the structure and function of nursing management, and demonstrated some similar findings to Strong and Robinson. The study included staff from across a Regional Health Authority (RHA), with approximately 400 interviews completed with managers, senior nurses and ward sisters. The project was commissioned by the RHA with the goal of eliciting “the views of senior nurses and general managers on the nature of these changes” (Glennerster et al., 1986, foreword), and focusing in particular on the impact of structural changes.

An interesting description of the transformation of the roles of the nursing managers and ward sisters was presented. Difficulties had arisen for managers due in part to the new accountability arrangements, with nurse managers holding dual accountability to general managers and to the profession. Problems were also identified for some nurse managers in articulating the position of the nursing profession to the managers, with problems compounded by the requirement to contain costs whilst maintaining the delivery of nursing care. The managers were found to stand at the centre of the new forms of accountability in the NHS, crossing the clinical and managerial divides. The former nursing hierarchy also exerted an effect over the nurses due to the power of tradition, which made it hard for staff to adapt to the changes and to the new management arrangements as:

Everyone carries around a map of the institutional framework in their heads. People have internalized the old Salmon structures to such a degree that it requires a huge psychological shift in relocating patterns of relationships (Glennerster et al., 1986, p. 26).

Similarly, the research by Harrison et al. (1992), also took as its starting point the impact of the reforms on clinical and managerial staff, in a study of 11 Health Authorities including two Scottish Boards. In this comparative ethnographic investigation 339 staff, at or below unit level including medical and nursing representatives, were interviewed using what was termed a loosely structured approach. This study is interesting for the inclusion of an extensive literature search and the design of a comprehensive theoretical framework using sociological constructs of power, organisational culture and puzzlement to support the research process. Accordingly, organisations are viewed as political systems populated by staff groups, of whom some hold multiple and conflicting objectives. The concept of puzzlement is used to describe the chance and uncertainty surrounding the development of these policy processes. The management theories of Fordism and post-Fordism were used to analyse the data, with the “Fordist” use of command and control through measurement, regulation and collection of data, contrasted with the post-Fordist working practices in which the emphasis is placed on organisational fragmentation, developing the organisational culture and employee commitment.

From the findings it was argued that the impact of the Griffiths’ reforms had been primarily structural, with managers found to have an over-riding concern with fiscal matters, measuring organisational efficiency and raising productivity without increasing costs. Finally, the loss of line management responsibility by senior nurses was reported, whilst the medical profession was described as having retained their autonomy.

Walby et al. (1994) also drew upon the concepts of Fordism and post-Fordism in a study considering changes in working practices and in the autonomy of the medical and nursing professions resultant from the reforms. Using a case study approach in hospitals located in Scotland and England, the researchers conducted interviews with

approximately 400 staff including medical, nursing and management representatives. In a detailed discussion the increase in managerialism and associated surveillance of the two professions was mapped, with a mixture of Fordist and post-Fordist approaches to management and working styles reported. In presenting the findings the researchers opposed the Fordist with the post-Fordist working practices of the nursing and medical professions. The nursing profession was found to be following Fordist working practices represented by a rigid and hierarchical management structure. This latter finding mirrors that of Strong and Robinson (1990). The nurses were also found to display less ability than their medical colleagues when it came to acting in autonomous ways or using decision-making skills. The use of Fordist practices were described as limiting the development of the nursing profession, although the researchers did suggest nursing was en route to a post-Fordist form of working. In this study, there is an implicit assumption that the post-Fordist working arrangements have merit. However, the researchers do not appear to have considered that post-Fordist working practices also represent a form of managerial control.

A number of studies were also conducted under the aegis of the King's Fund, and reported on by Robinson and Le Grand (1994). These projects were undertaken to evaluate the impact of the implementation of the *Working for Patients* reforms (DoH, 1989) and were small scale and exploratory in approach. Amongst the topics included were: assessments of the performance of NHS Trusts; GP Fundholding and, medical audit. The findings demonstrated few identifiable improvements following implementation of the reforms, although the absence of evaluative criteria was noted as having presented problems. The report of particular interest is the descriptive account by Kerrison et al. (1993, 1994) of the development of medical audit in four hospital sites. Data collection was conducted by observation of local audit committee meetings and interviews with key participants including clinicians, audit co-ordinators, nurses and managers. The findings demonstrated a narrow interpretation of audit, domination by senior doctors, lack of clear guidelines and standards and little management involvement. One area where medical audit was found to be successful was in the concentration of audit projects on the technical aspects of patient care, which was described as opening the work of junior doctors to view and

discussion at the audit meetings. This allowed the consultants to participate in the audit process, although the audit did not include a direct focus on their work, enabling them to disappear from view. The junior doctors were described as viewing audit meetings as a socialisation process, a means of learning about consultants' expectations and local policies, rather than about new developments. The authors noted that although the medical profession had argued for medical audit to be an educational rather than managerial activity, it was unlikely that the issues identified would lead to formal training. In conclusion the use of medical audit as a type of formative evaluation was described as increasingly out of step with the summative measures being implemented elsewhere in the NHS. Overall the authors observed that involvement in medical audit had a "symbolic quality" acting as "visible proof of the 'clinicians' commitment and vocation" (Kerrison et al., 1994, p. 175).

The study by Traynor (1994, 1996, 1999) represents an important example of nursing research, taking as its focus the way in which nurses and managers present themselves and argue their case within a context of increasing rationalism and associated development of managerialism. The research is located in the context of the managerial reforms, looking at the effect of management activity on community nurses and nurse managers. A theoretical perspective is presented of the dominant trend of managerial rationalism in society and the NHS, which is linked with the discourse used by nursing leaders. Analysis of this demonstrated "that nursing leaders have continually reshaped discourse about the profession - in response to changing discourses in society" (Traynor, 1999, p. 82). Earlier nursing discourses were seen to have responded to feminism and, more recently, the trend of economic rationalism, with nursing managers drawing increasingly from the language of economic rationalism and bureaucracy to present nursing as a cost effective activity.

The study originated as part of an RCN study conducted in four first wave community Trusts, although one Trust subsequently withdrew from the study. The researcher collected data over a four year period from the two groups of staff using two separate collection methods. First, interviews were held with 19 managers, and second, the additional comments were collected from a separate job satisfaction

questionnaire completed by all the community nurses employed in these Trusts. This questionnaire formed part of an RCN study on job satisfaction which had included free text space for staff to provide additional comments. Some 886 questionnaires from the job satisfaction study were included in the analysis. The variation between the methods used to collect the data gives some cause for concern in terms of hearing the voice of the community nurses. It is interesting to note Traynor's observation that the responses obtained from community nurses were primarily in the negative, although he also argued (Traynor, 1994) that the material obtained by these means provided a rich source of data.

The research approach was informed by deconstructive literary theory and discourse analysis, with the deconstructive approach used to enable exploration of texts which simultaneously supported opposing positions. This approach was also based on the premise that the structure of language reflects the existing power relations in society. Consequently, particular attention was paid to the link between power, language and identity, and to the philosophical positions implicit in the talk of managers and nurses. Traynor identifies the managers as using a rationalising discourse drawn from the language of modernity, a discourse characterised by the use of impersonal criteria and reliance on measurement processes. In this discourse the concept of measurement formed a new and authoritative language, although problems were identified by some managers in applying this approach to nursing care. However, for the managers the tasks represented by this discourse were imperatives which had to be completed, and with which the community nurses had to comply. Traynor argues that:

the unspoken implication is that the survival of certain groups of community nurse depends too upon this 'demonstration'. They have to 'make up their minds', 'sit down' and enter into the project of increasing explicitness and formally rational activity (Traynor, 1999, p. 101).

The research also identified variation between managers themselves, with some trying to reconcile the differing discourses of the managerial and nursing groups. The analysis of the community nursing position contrasts strongly with that of nursing

management, highlighting a sharp division between these two groups with the managers adopting a position of objectivity and detachment whilst the nurses convey moral outrage at the managerial developments. The managers were depicted as adopting a position based on the unarguable rationality of financial constraints and the use of means of surveillance, although some were also said to experience “unease and anxiety at the unintended consequences of such accounting procedures” (Traynor, 1999, p. 158). Throughout the study managers were presented as ‘wily rhetorician[s]’ with a ‘will to persuade’. This view of management follows from that presented by MacIntyre (1985), and identifies three means of enacting community management: self disclosure, development of community teams and finally by:

appealing to finance as a given and to attractive notions of professional autonomy and even patient empowerment enabled managers to adopt a rhetoric of offering freedom of choice to field staff while actually exercising detailed and overarching control (Traynor, 1999, p. 160).

Traynor indicates that the success of this management approach is based on the managers presenting the majority of community nurses as irrational. The findings of the research present the community nurses as an exploited and disempowered group, adopting and negotiating a position of subjectivity from the conflicting discourses of caring and exploitation, and portraying themselves in terms of duty and self sacrifice. For the majority of the nurses, the official discourses of management were found to have little relevance, although Traynor notes that there was no way of knowing why this was so from the findings of this study. The research findings indicated that whilst the managers were promoting nursing as a rational and cost effective activity, the nurses themselves were viewed as traditional, irrational and fearful. As a consequence there was a marginalisation of the nursing group, their discourse and the knowledge that they espouse. This factor is summarised by the statement that the project:

may represent the dying voice of a fading group or it may characterise a more robust position of a significant, but nevertheless unsanctioned nursing subgroup. [...] However, its very negativity, lack of both political finesse and effectiveness and its failure to obey ascendant rules of

rationality lend this project an admirable freedom of concept and argument. The nurses [...] can voice unease, powerlessness, a sense of contradiction and anger in a way that more 'rational' operators who have more to lose in terms of credibility, power, position and influence can rarely achieve (Traynor, 1999, p. 156).

1.3.2 Clinical governance

Whilst the 1983-1991 reforms were associated with a lack of government interest in evaluating the reforms (Robinson and Le Grand, 1994), this situation has evidently changed (Donaldson and Gray, 1998). An interesting feature of the clinical governance agenda has been the increase in the number of evaluation studies conducted (Freeman et al., 1999; Walshe et al., 2000; Franks, 2001; Grainger et al., 2002). Although these studies can be viewed as meeting the criteria identified by Flynn as being more "for" policy than "of" policy (Flynn, 2002), they nevertheless provide a valuable window on the development of the agenda.

Amongst these are a series of studies completed for the West Midlands Health Authority (Latham et al., 1999; Walshe et al., 2000), conducted to provide empirical evidence on the progress of the clinical governance initiative. In the final report associated with this study, Walshe et al. (2000) provide not only an overview of the analysis but also a theoretical review covering many aspects of the clinical governance agenda. The analysts locate the initiative within the tradition of NPM and a whole systems approach to quality, tempered by a modified professionalism (Walshe et al., 2000, p. 57). The study included structured interviews with 151 key individuals including the clinical governance leads, medical directors, nursing directors and chief executives of the Trusts in the region. This approach of interviewing the senior clinical and managerial echelon of the organisations mirrored the tried and tested means of research into the earlier NHS reforms (Harrison et al., 1992). From the findings it was evident that many of the organisations had developed the systems required by the agenda, including clinical audit, risk management and management of complaints. These developments were, however, depicted as limited and at odds with the reported use of a whole systems approach to quality improvement. The supporting structures were described as fragmented with problems

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identified in developing the organisational culture required to integrate and progress the various components of the clinical governance agenda. There were also difficulties in providing the time and resources for those individuals leading the initiative, with little evidence of clinical governance forming an integral part of clinical practice, or of changing clinical care.

A series of investigations was conducted by Degeling et al. (2001, 2003, 2004). Here the research aims included the identification of how medical and nursing staff balance clinical autonomy with accountability to managers; recognise interconnections between clinical and financial aspects of care; accept the multi-disciplinary nature of care; and participate in processes designed to bring work under process control (Degeling et al., 2001). The research design divided the health professions into four sub-cultures, nurse managers, nurse practitioners, medical managers and medical clinicians, with each group described as pivotal to the successful interpretation of the reforms. Additionally, the perception and interpretation of the reforms by the medical and nursing managers were viewed as particularly crucial due to their positioning at the intersection of the managerial and clinical domains.

Two studies were conducted in hospital locations distributed through the United Kingdom, New Zealand and Australia with a total of 856 and 3,065 respondents included in the respective studies (Degeling et al., 2001, 2003). In both instances staff were issued with a self-completion questionnaire, comprising closed questions on key health care issues including the prevalence and causes of variations in clinical practice, stability and adequacy of clinical knowledge and clinical standard setting. Statistical analysis was used to interpret the data, with the most frequently identified variations being associated with occupational background. Whilst this approach enabled the collection of data from large groups of staff, the design of the questionnaires and use of closed questions inevitably precluded the collection of additional information from respondents.

The findings were presented by sub-professional groupings and it is perhaps unsurprising that, given the data collection method, nurses were identified as: having a low assessment of nursing power; inclined towards decision processes based on rules and custom; preferred team-based working arrangements; and believed that following protocols would extend their autonomy. Nurses were also identified as having a patient centred concept of clinical care and held the view that issues of resources had no place in clinical decision making. The nurse managers were aware of the disparities of power in health care. They also supported rule based decision making and were keen to promote rationalised, codified, standardised and accountable work processes. A contrasting picture was found for the medical sub-groups although the differences between the two groups were only to a minor degree and as such are described as difficult to profile.

The reservations noted, concerning the design of the questionnaire and use of closed questions to collect data, were addressed by a smaller study of staff working in five NHS Trusts in Wales (Degeling et al., 2004). This study focused on staff knowledge of clinical governance including objectives, outcomes and staff perceptions of the policy. In this instance focus groups were combined with the use of the questionnaire which included closed and open questions, and further information was collected on the interaction between the groups. A total of 198 members of staff representing the four sub-groups were involved in the focus groups. The findings illustrated the negative view of clinical governance held by the medical staff. By contrast, the nurse managers were described as having extensive knowledge and experience of these issues and were identified as being the group most able to lead the implementation of the clinical governance agenda. As a result of these findings, a number of recommendations were put forward. Firstly, that the commitment of health professionals to patient centred clinical services should be recognised in planning future reforms. Secondly, it was proposed that a model based on responsible autonomy and multi-disciplinary care pathways, rather than instrumental, calculative and resource management models, be used to promote transparent accountability. It was suggested that this system would retain a patient centred approach to the

delivery of care. Finally, Degeling et al. (2001) argued for a negotiated balance between the respective discursive domains of management and practice.

The role of medical staff working on the boundary between the clinical and managerial domains has received increasing interest from researchers (Llewellyn, 2001). This trend is represented in the studies by Harrison and Dowswell (2002) and Sheaff et al. (2003), which are concerned with changes in medical autonomy arising from social and political developments, with the primary focus on the impact of developments in knowledge and the role of medical leaders. Harrison and Dowswell (2002) present just such an analysis in their study of the clinical autonomy of general practitioners. Specifically this study was concerned with investigating the perceptions of general practitioners related to government policies, recent governance developments and whether or not developments were affecting their ability to determine clinical practice and to judge their performance. The study draws from three strands of theoretical analysis, bureaucratisation, de-professionalisation and decline in collegiality. The study was also informed by a scientific-bureaucratic thesis (Harrison and Ahmad, 2000; Harrison, 2002; Harrison et al., 2002b) in which changes in medical autonomy were related to changes in medical knowledge. It is argued that these developments were associated with increasing reliance on scientific-bureaucratic medicine as represented by the recent development of clinical governance and EBP.

A series of semi-structured interviews were conducted with 49 GPs in eight PCGs located in two health authorities in England, using thematic content analysis to identify major themes in the data. The authors present the data as indicative of an increase in the development of bureaucratic accountability, a reduction in the physician's ability to set limits on and to judge their own performance. These developments were also viewed as enabling others to survey their work. In particular those physicians acting in a managerial capacity were found to be placing pressure on GPs to modify their casenote recording. Interestingly, the respondents were found to have offered little professional resistance to these developments, other than expressing regret related to disregard for the tacit "art" of professional knowledge.

The study also identified the role of the practice nurses in the spread of bureaucratic accountability with the GPs delegating certain patients to the nurses, thus freeing time to sort out “guidelines for the practice” (Harrison and Dowswell, 2002, p. 214). It is argued that the nurses are:

keen to expand their role. I don't see any threat; the nurses don't want to kick us out of the business, but one day what we see as general practice will become primary care nursing duties, as a lot has already (Harrison and Dowswell, 2002, p. 214).

The authors argue that the findings were consistent with a number of theoretical perspectives including de-professionalisation (Haug, 1988), the concept of Foucauldian ‘panoptic surveillance’ (Foucault, 1977), bureaucratisation of medical knowledge (Harrison, 2002) and representative of a shift from trust of people, to trust of systems (Power, 1997). The researchers concluded that these findings indicated the continuing loss of medical autonomy and restratification of the medical profession.

Sheaff et al. (2003), conducted a study of medical leadership in primary care, to explore how a profession adapts the way it regulates itself in response to the constraints of new public policies, governance structures and the desire to self regulate. The theoretical foundation of the research drew upon Courpasson’s (2000) concept of soft bureaucracy, which argues that the management of professionals is achieved through the use of sophisticated management practices. According to Courpasson, professional organisations comprise a hard exterior and a loosely coupled interior, with the former encompassing the contractual systems and penalties associated with employment. In contrast to this, the interior of organisations and the management of professionals are based on the creation of flexible corporatism with professional leaders appointed to managerial positions and given weak management power over their colleagues. Courpasson argues that this is based on three legitimacies: firstly, instrumental legitimacy concerned with promoting organisational goals; secondly, political legitimacy with the professionals having renunciated control to the professional lead; and finally, liberal legitimacy in which

the lead professional uses techniques of soft coercion associated with the external threats. Soft bureaucracy presupposes the existence of a bureaucratic governance structure and the authors indicate that modification will be required to fit with the network arrangement of GP practices in PCGs and PCTs.

The empirical study focused on the development of clinical governance in 12 primary health care networks and the associated implementation of two National Service Frameworks (NSF): one for coronary heart disease and one for mental health. These NSFs were chosen for the contrasting degree of clinical detail they provided. A case study approach was used across the sites, with 49 semi-structured interviews carried out with chief executives, clinical governance leads including two nurses, mental health leads and lay informants. Case studies were produced for each site by triangulation of the data. These were subsequently used to identify commonalities and differences between sites and as a means of “narrating how clinical governance was established and performed” (Sheaff et al., 2003 p. 413).

Clinical governance was found to be legitimated through primarily instrumental means, including problem-solving tasks, persuading staff to accept self-imposed targets, and the use of technical language. The authors also described the introduction of benchmarking as an example of surveillance, likening this to opening the practice of individual doctors to the collective gaze of the profession (Foucault, 1977), and the use of technically legitimated rules which thereafter regulated individual performance. The authors propose that Evidence Based Medicine (EBM) was used to maintain medical dominance in the face of processes of bureaucratisation. Some variation was found in the reaction of the GPs to the NSF and whilst failure by the GPs to follow the frameworks was found to be indefensible, GPs preferred the more clinically prescriptive NSF for coronary heart disease, than the less specific mental health NSF. The primary rationale for following guidelines was however expressed in terms of meeting clinical requirements rather than that of policy:

Although clinical governance activity was legitimated in strongly instrumental terms, this instrumental justification

referred to the technical, health effects of 'good' clinical practice, not its contribution to other health policy or NHS management objectives (Sheaff et al., 2003, p. 418).

Overall, clinical governance was viewed by the physicians as having been a *force majeure*, which would be implemented whatever the medical opinion. Although the clinical leads were found to be concentrating on the development of trust, encouraging the use self criticism and a reliance on development and training, they were also found to have used soft coercion on their colleagues, expressed in terms of the external threat of management action and government led reforms. The authors argued that the study illustrated how the managers influenced staff by proxy through the clinical leads who were acting in a boundary position. Importantly, although this was argued as reducing the power of individual physicians, it was not viewed as reducing the power of the medical profession. Finally, soft-bureaucracy was found to reveal the motivational processes used to obtain compliance from the physicians as complex and ambivalent, including managerial incursion on medical decision making, tighter financial controls and more paperwork.

Harrison et al. (2002a), reported on the findings of a study of practice nurse attitudes towards the use of clinical guidelines. This study was conducted consecutively with another on GP attitudes to guidelines (Harrison et al., 2003) and found that the two groups held contrasting opinions. The background for this study was the increase in the number of practice nurses employed in general practice and the delegation of work from the GPs to the nurses, a process largely dependent on the existence of guidelines. Twenty six practice nurses were each interviewed on three occasions, with the first interview using a Likert style questionnaire concerned with attitudes towards clinical guidelines. The second interview used a further questionnaire, this time related to the organisational culture and qualitative data related to their perceptions of current developments including creation of PCGs. Finally, the third interview focused on discussion of the preliminary findings.

The nurses were found to be generally supportive of the use of clinical guidelines and to have gained considerable autonomy over the care of some patient groups, for

example those with asthma, and others where GPs were found to have abdicated interest. Some medical staff were reported to be bored with guidelines and to denigrate nursing interest in them. However the nurses identified various advantages in using guidelines including: the promotion of consistency; as a source of expertise; providing a degree of autonomy in practice; and, also as a source of protection for the nurses. The nurses also indicated that they had used guidelines in discussion with the GP, and expected to be involved in the processes of guideline development stating:

We developed some practice guidelines for the management of coronary disease. They are interdisciplinary. This will make them acceptable to the GPs and practice nurses. We reviewed the evidence, looked at the National Service Framework, considered clinical governance, and chose an area which is one of our local priorities (Harrison et al., 2002a, p. 304).

These findings are similar to those of Degeling et al. (2001), with the nurses indicating a preference for codified knowledge and, although the use of guidelines are considered to reduce professional autonomy, the study suggests that in some contexts autonomy can be gained from their use. The research is also important for evidencing the degree of transition in the practice nurse role and, although a wider study would be required to consider the influence of interprofessional factors on these findings, the authors suggest that this study supports Berg's (1997) thesis that the explicit codification of the scientific basis of the work of low status groups may in fact enhance their status.

The final study considered in this section was the small scale study of practice nurses conducted by Savage and Moore (2004). This study arose from concerns that current government led reforms failed to recognise the impact that the hierarchical structure of health professions has on multidisciplinary working. Amongst issues identified by the authors were the failure to acknowledge the ambiguous nature of accountability across the health care team and a dilemma arising from the emphasis placed by members of the nursing profession on individualised care, as opposed to a concern

with the care of populations, underpinning the development of EBM. It is also proposed that:

the multidisciplinary working heralded by clinical governance may rest on decision-making predominantly shaped by the knowledge of the most powerful disciplines (Savage and Moore, 2004, p. 7).

These factors, it is suggested, will impact on nursing involvement in the implementation of the government's modernisation agenda.

The researchers focused on the interpretation of accountability by practice nurses in the context of clinical governance. They questioned how accountability was understood across the care team, who was involved in multi-disciplinary decision making and the relationship between decision making and accountability. An ethnographic study was used involving all staff employed in one GP practice, including nurses, administrative and medical staff. Data collection was by way of semi-structured interviews, observation and use of vignettes. The findings indicated that the meaning of accountability for practice nurses was elusive, being used in varying ways and as a catch-all term. The researchers also indicated that accountability could be passed:

like a hot potato from one practitioner to another, principally by providing a colleague with a narrative or an account of decision-making. Although some nurses saw themselves as accountable for their practice, a contrasting view was also evident amongst all staff, promoted perhaps by the set-up of the practice as a small business (Savage and Moore, 2004, p. 5).

The main limitation of this study was its small scale, resulting in it being viewed as an initial overview of the topic. Despite its small scale this study was useful for identifying the impact of the recent developments on the practice nurse understanding of accountability. Their view of accountability was described as ambiguous and especially confusing due to the development of clinical governance and EBP. Concerns were also identified related to nursing knowledge being shaped

by powerful disciplines and that the structure of this knowledge was failing to recognise nursing goals and accountability.

1.4 Summary

The aim of this chapter was to review the literature on clinical governance with particular regard to the policy antecedents, development of a quality agenda in health care and relevant empirical research. From this review, it is evident that the literature presents a partial picture of the reforms and of nursing involvement, largely characterised by a concern with examining the development of management and organisational systems (Strong and Robinson, 1990; Harrison et al., 1992; Walshe et al., 2000), changes in working arrangements and the impact of these reforms on health professions (Walby et al., 1994; Harrison and Pollitt, 1994; Harrison and Dowswell, 2002). In many instances the focus is placed on the senior management tier of NHS organisations, with comparatively little indication of the impact of developments on staff at clinical level, although there are notable exceptions (Glennerster et al., 1986; Glennerster and Owens, 1987; Traynor, 1999; Harrison et al., 2002a). In terms of the implementation of clinical governance there were a number of organisation wide evaluations which illustrated the primary focus on the development of structures for clinical governance and the use of NPM and CQI as models to inform the development (Walshe et al., 2000). It was also shown that in a few instances nurse managers held the position of clinical governance lead. A number of small scale studies were also evidenced by the review, examining the impact of the reforms on the role of the medical profession, including changes in medical autonomy and the codification of the medical knowledge base (Harrison and Dowswell, 2002; Sheaff et al., 2003). Whilst the aim of clinical governance was the development of corporate accountability for clinical quality, the review showed that there were few studies concerned with this aspect of the agenda.

The literature review traced quality related activities and the development of independent strands, organised in the majority of instances along professional and managerial lines. The review revealed a notable gap in research in this area, even though the nursing profession was described in the literature as being active in

quality related developments (Harrison and Pollitt, 1994). The literature also identified the process whereby in some instances, those nurse managers who had been dispossessed by management reforms were appointed to quality management posts. These posts were established throughout the NHS and their creation has been described as developing an accidental lobby for quality. However, in terms of the development of the quality agenda there is little information other than descriptions of the main methods employed and the projects implemented.

As with quality management in the private sector, the review illustrates a surprising dearth of research on quality related topics at the level of organisational management. Whilst there were references to the involvement of members of the nursing profession across a wide range of quality related activities, there were few specific studies related to the actual involvement of nurses in projects. The literature indicated some development of organisation-wide quality systems using private sector techniques but it is suggested that nurses, concerned with the improving patient care, preferred their own local systems.

A few studies highlighted issues associated with nursing knowledge. Amongst these, early studies suggest an initial inability of nurse managers to fulfil the quality roles, due to a range of factors such as a lack of managerial support and knowledge (Strong and Robinson, 1990). This view differs from that of a later study where nurse managers are identified as being the most knowledgeable on the quality management reforms and consequently, are considered to be the staff members best suited to lead these initiatives (Degeling et al., 2004). Harrison and Pollitt (1994) cautioned that the positioning of nurse managers on the “boundary” between management and nursing was opening the profession to the management view. This positioning on the boundary has recently become an object of interest for research focused on the impact of management reforms on the medical profession, but a gap remains in the research related to the role of the nurse manager. Additionally, there has been recent interest in the boundary role of clinical leads in the medical profession (Sheaff et al., 2003).

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The relationship between the managers and the nurses is given little consideration in the research literature, although Traynor (1996, 1999) provides an obvious exception to this with his study of community nurses and managers. In this study the nurse managers are represented as using a rationalising management discourse, with a sharp distinction drawn between the two groups who are depicted as having divergent goals. Consideration of this study, however, is tempered by concerns regarding the means used to collect the data from the community nurses.

Developments in guidelines and protocols are also mentioned in the research literature. It is suggested that nurses prefer to use guidelines and protocols and they view this as increasing their autonomy (Harrison et al., 2002a). In contrast to this, the medical profession was reported to hold the view that guidelines are an encroachment on their medical autonomy (Harrison and Ahmad, 2000; Harrison and Dowswell, 2002; Sheaff et al, 2003).

The research methods used were mainly qualitative and descriptive with little theoretical development (Ferlie, 1997) although there were some exceptions with the use of complex theoretical frameworks, including those derived from Weberian theory (Harrison and Dowswell, 2002; Sheaff et al., 2003). A number of studies also used innovative approaches for example Traynor's application of the deconstructive approach (1996, 1999) which was used to explore the dualism evident in the respondents' accounts. A further example is the study by Strong and Robinson (1990), in which the expertise of the interviewee was acknowledged and the interviews used as a tool to explore conjointly the reform agenda, with the findings presented as a series of stories.

The review also demonstrated the paucity of nursing research on clinical governance and the NHS management reforms. Whilst this can be explained by the comparatively early stage of the development of the agenda, widening the review to include nursing research related to NHS management reforms (1983-1997), identified few additional studies. The inclusion of Strong and Robinson's (1990) study, on the basis of the significant focus on the nursing profession, did little to

strengthen the field of nursing research. It is also evident that the studies reviewed were conducted in response to significant policy led reforms of NHS management. This lack of research represents a significant weakness, with little evidence of a developing discipline of organisational and policy research by nurse researchers, and therefore confirms the findings of Rafferty (1992) and West and Scott (2000).

It is however possible to make the following observations regarding the strengths and weaknesses of current research studies. Firstly, the majority of studies adopted an organisation wide research focus, thereby providing for consideration of complex organisational settings and including a range of staff in the research process (Glennerster and Owens, 1986, 1987; Strong and Robinson, 1990; Traynor, 1996). These studies were, in the main, primarily concerned with the managerial tier of the organisations considered and consequently the inclusion of clinical nursing staff was infrequent. Savage and Moore's (2004), presents an obvious exception to this and, importantly, considers the influence of other members of the multi-disciplinary team. This was however an exploratory study and lacked an in-depth analysis of staff interaction. Secondly, policy research has been described as being either "of" or "for" policy (Flynn, 2002, p. 156) and it is evident that the majority of studies were "of" policy, considering the effects of policy developments. An exception to this was provided by Glennerster et al. (1986) and Glennerster and Owens (1987), with this study appearing to present a "for" policy examination. Finally, with regards to methodological and theoretical considerations the studies drew primarily upon qualitative methods, including in-depth interviews, questionnaires, observation and vignettes and with little use of quantitative data. The studies were mostly exploratory and concerned with generating ideas, providing little evidence of the use of theoretical models drawn from policy studies, nursing or organisational research. Traynor provides a notable exception through use of postmodern theories and a deconstructive approach.

In conclusion, whilst the development of new accountability arrangements is a primary goal in the clinical governance agenda, this concept has received little treatment in the literature and research, with the notable exception of Dewar (1999,



2000) and Savage and Moore (2004). To understand the implications of corporate accountability for clinical quality and the nursing profession, accountability needs to be considered against the wider context of the nursing profession and organisational control.

Following from this, the next chapter will examine some of the writings and theoretical perspectives used to study the concept of accountability and discuss their relevance for the topic of this study.

Chapter 2

Theoretical perspectives

Whilst the concept of accountability occupies a central position in the clinical governance agenda, the incomplete and contingent nature of this concept has also been acknowledged (Dewar, 1999, 2000). To identify a theoretical perspective for the study, this chapter considers the treatment of accountability across a range of literature representing the nursing profession, organisation control and management. It has been suggested that more accountability is self evidently a good thing (Jacobs, 2004) and it is apparent that accountability has over the past two decades formed an increasingly explicit text in government policy, professional, and management agendas (Munro, 1996; Czarniawska, 1997; DoH, 1998; Tilley and Watson, 2004). However, accountability is evidently a problematic concept, with descriptions ranging from “a cherished concept, sought after but elusive” (Sinclair, 1995, p. 219) to “hydra-headed” (Watson, 1995a, p. 2) and “Janus-faced” (Tilley, 1995, p. 124). This difficulty notwithstanding, the introduction of clinical governance caused a resurgence of interest in the concept of accountability among policy analysts, health professionals and managers (Klein, 1998; Baker et al., 1999; Dewar, 1999, 2000; Allen, 2000), although the response in the nursing literature has been limited (Tilley and Watson, 2004; Savage and Moore, 2004).

Consideration of the literature identified various concerns associated with defining terms, the impact of new accountability arrangements within organisations, the centrality of accountability processes in social interaction and the construction of the self in particular involving narrative processes. The literature presents and explores these with reference to theories propounded by analysts including Garfinkel (1967), Foucault (1977), Habermas (1971, 1987), MacIntyre (1985, 1988) and Bruner (1986, 1990).

2.1 Defining and conceptualising accountability

A central feature particularly in the nursing literature is a concern with defining the concept of accountability, identifying related concepts and classifying the relationship between the uses of these terms. This section reviews that literature

concerned with defining accountability, beginning with the nursing profession's use of taxonomies and codes of professional conduct. Although, this literature is evidently at an early stage of theoretical development, it is nevertheless important for identifying the strands of concern to the profession. This section then turns to consideration of the processes involved in the construction of accountability by Chief Executive Officers (CEO) in the Australian public sector, in which accountability is presented as a contingent and ever changing concept (Sinclair, 1995).

2.1.1 Nursing accountability

The centrality of accountability in discussions related to the professional agenda of the nursing profession has been acknowledged (Watson, 1995, 2004; Jacobs, 2004), which makes the comparative absence of theoretical analysis of the concept somewhat surprising (Savage and Moore, 2004). The intention of this section is not to review all aspects of this literature, but rather to focus on approaches to defining and conceptualising accountability as represented within the nursing literature. Amongst the means identified were three recurrent themes: use of taxonomies of related terms to categorise accountability; identification of accountability due to "referent others" (Lewis and Batey, 1982, p. 10); and finally, reference to the codes of professional conduct. The literature also includes reference to the changing nature of the professional accountability of the nursing profession and the impact of management reforms.

In the nursing literature accountability is frequently defined by referring to other concepts, with responsibility, authority and autonomy amongst the most frequently discussed (Batey and Lewis, 1982; Lewis and Batey, 1982; Duff, 1995; Tilley, 1995, 2004; Savage and Moore, 2004). Each of these terms invited extensive treatment, with Tingle noting that whilst the attempt to define accountability is a tautological exercise it is nevertheless useful (Tingle, 2004). A cautionary note is also raised by Day and Klein (1987), in their research into public sector accountability, against confining the analysis in a "mechanistic, verbal strait jacket", or of implying by the:

choice of words used that the effectiveness of a system of accountability can be evaluated in terms of the appropriate connections being made (Day and Klein, 1987, p. 29).

An influential exposition of this approach to examining nursing accountability provided by Batey and Lewis (1982) and Lewis and Batey (1982), remains a primary reference for the nursing literature (Duff, 1995; Savage and Moore, 2004; Griffith and Tengnah, 2005). Batey and Lewis (1982) and Lewis and Batey (1982) present a predominantly structural account, constructed from closely argued and defined terms and with the inter-relationship between these carefully delineated. This provides a useful exemplar of a means of conceptualising nursing accountability, concerned with enabling the development of working arrangements which it is argued will foster the development of autonomy and accountability. The authors add that “clarity of position is essential to establishing the appropriate domains of professional type nursing” (Batey and Lewis, 1982, p. 14).

Their definition of accountability was developed following an extensive literature review and a series of interviews conducted with the directors of nursing of 12 small hospitals in the United States of America. The authors used these sources to develop a hierarchy of terms, including responsibility, authority and autonomy, with each term defined from a structural rather than attitudinal perspective. Accordingly, responsibility is defined as “a charge for which one is answerable” (Batey and Lewis, 1982, p. 14), authority as the “rightful (legitimate) power to fulfill a charge” (1982, p. 14) and autonomy as the “freedom to make discretionary and binding decisions consistent with one’s scope of practice and freedom to act on those decisions” (1982, p. 15). These definitions provide the foundation and necessary preconditions for the definition of accountability as:

the fulfillment of a formal obligation to disclose to referent others the purposes, principles, procedures, relationships, results, income, and expenditures for which one has authority (Lewis and Batey, 1982, p. 10).

Interestingly this approach, whilst deriving its authority from the use of external sources of evidence and also from locating itself in an organisational structure,

largely ignored the influence that some organisational structures and the agents within the system have on the development of nursing accountability. Thus, Jacobs (2004), condemns Batey and Lewis for their uneven analysis and failure to engage with the literature on organisations and the issue of the power of other groups within the health care setting. Batey and Lewis have evidently failed to consider the implications of the organisational structure for the members of the nursing profession in terms of enacting nursing accountability although, ironically, their empirical evidence provided examples of the influence of other groups on the profession.

Considerable confusion is illustrated by Batey and Lewis' treatment of accountability and power as is apparent from their statements that "it is fallacious reasoning to equate accountability with recourse and sanctions" (Lewis and Batey, 1982, p. 12), whilst, noting a page later that:

Accountability could, if deviously used, provide information to support containment and tight control over nursing service goals and functions. By making nursing's purposes, processes and outcomes visible, nursing places referent others with knowledge of such detail in powerful positions (Lewis and Batey, 1982, p. 13).

The second approach to examining accountability is the identification of the forms of accountability due by members of the nursing profession to "referent others" (Lewis and Batey, 1982, p. 10), with Tingle providing an extensive list including colleagues, patients, profession, employers, management and the law. Mander (2004) describes a hierarchy in which four forms of accountability are held by midwives: institutional, to the woman, personal and professional. Of these, personal accountability is equated with the highest order and organisational with the lowest form of accountability, although it also noted that:

The lower order forms of accountability, such as the organisational form, may have more easily apparent consequences in terms of the potential for disciplinary action and implications for employment (Mander, 2004, p. 138).

Difficulties are also noted by some analysts in balancing these various accountabilities (Jacobs, 2004; Tilley, 2004), as represented by Duff's (1995) attempt to clarify the relationship between professional and organisational approaches to the use of quality assurance systems. It is with these difficulties in mind that Batey and Lewis (1982) and Lewis and Batey (1982) attempt to present and clarify the nature of nursing accountability.

The impact of the introduction of clinical governance and increasing use of EBP on organisational and professional accountability, are also treated by a number of analysts (Jacobs, 2004; Tilley, 2004; Mander, 2004). For Mander this is exemplified by the emphasis the clinical governance agenda places on the use of clinical audit and EBP, which is viewed as a downgrading of professional knowledge to that of mere numbers. In consequence, it is stated that the human knowledge "such as intuition, occupational experience, personal knowledge and gut feeling, may no longer be permitted to feature in the repertoire of the accountable practitioner" (2004, p. 141).

Tilley's (1995) study, set in the context of mental health nursing, presents an alternative approach to the conceptualisation of accountability, by drawing upon an interpretivist approach in which accounts are also considered as part of establishing and consolidating the nursing role. In a continuation of this study Tilley (2004) presents an examination of the impact of the NHS management reforms and the clinical governance agenda on the nursing profession. By using an analytical framework in which accounts, accounting and accountability are treated as a series of working words, the inter-relationship between knowledge, power and moral order are explored. Thus accountability becomes framed in a professional, organisational and institutional structure, which moves these words beyond an unproblematic giving and receiving of accounts to consideration of the:

wider debates and struggles over what constitutes a legitimate account, a legitimate system of accounting, and accountability (Tilley, 1995, p. 129).

Accordingly, accounts are discursive events “which interpret the situation and order action within it” (Tilley, 2004, p. 160); accounting is the explaining and assigning of responsibility for action in terms of systems and processes; and, finally, the concept of accountability refers to the obligation to participate in processes of accounting. Interestingly, the reflexive and interpretive processes associated with clinical governance are also presented with the statement that “we shape the society in the context of which we consider accountability and clinical governance, and are shaped by it” (Tilley, 2004, p. 158).

Tilley identifies significant changes in the nursing account resulting from the development of clinical governance including within this the accountability due to managers, resultant from the joining of resource and quality related matters under a single agenda. The reshaping of mental health nursing practice arising from the use of EBP is also considered. Tilley describes this as giving rise to the development of a “highly *role-bound* accountability” (2004, p. 162) for “deliverable interventions” with, it is suggested, a reduction in the ability of nurses to meet their professional remit in delivering person centred care. Thus the developing use of medical discourse is identified, with:

‘Clinical’, ‘performance’, ‘standards’, ‘making accountable’, ‘individuals’ are ingredients in a modernist recipe, with the key term ‘accountability’ [...] Thus, ‘hidden’ in the policy announcing clinical governance was a more powerful form of professional accountability grounded in the voice of medicine (Tilley, 2004, p. 165).

Tilley (2004) also locates the current code of conduct for the nursing profession in these developments, being concerned with the escalation of a top down discourse of evidence based care and with the increasingly powerful voice of the medical profession (NMC, 2002, 6.5). The nursing profession has a long history of defining codes of professional conduct both internationally (Tschudin, 1992, 2003; Pattison, 2001), and nationally with successive codes being published by the UKCC and NMC (UKCC, 1992; NMC, 2002, 2004). The most recent version of the code contains:

standards for conduct, performance and ethics for the professions. It is the key tool to enable public protection by ensuring that all registrants are supported to provide expert and safe care to patients (NMC, 2005, p. 1).

Accordingly, being accountable is defined as being “responsible for something or to someone” (NMC, 2002, glossary), with the code setting out the scope of this accountability as including relationships, skills, knowledge, and competence. The summary statement indicates that the basis for all of this lies in personal accountability:

As a registered nurse, midwife or specialist community public health nurse, you are personally accountable for your practice (NMC, 2004, p. 3).

A critical but limited debate has been associated with the development of the professional codes (Hunt, 1991; Tilley, 2004). A stronger critique of these developments is provided by Pattison (2001), in a study focused on the UKCC *Code of professional conduct* (UKCC, 1992), who questions whether or not professional codes of conduct have an identifiable ethical base. This particular article is based on an earlier version of the code but is interesting for evidencing an approach concerned with the promotion of debate and discussion of such documents. Pattison offers a view of codes of conduct as systems which enable the promotion of dialogue and discussion, relating in particular to the complex ethical issues arising in health care. In the context of this overview Pattison describes the UKCC code as embodying terminological inexactitudes, confusion, an arbitrary selection of values, a lack of ethical guidance and the exclusion of everyday ordinary moral experience. Pattison also questions the failure of the authors of the code to identify themselves, or to explain their reasons for choosing particular moral principles. The use of an imperative tone throughout the UKCC code, it is argued, indicates a failure of the nursing profession to promote a culture of learning and questioning, with Pattison asserting that this code is:

wholly undialogical; there is no process of internal questioning in it, nor does it pose useful questions that may be susceptible to a number of different ethical responses from

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practitioners. It requires and models obedience rather than thought (Pattison, 2001, p. 14).

This section has identified various approaches to defining nursing accountability and, although this provides examples of practical theorising essential to both praxis and theories of practice (Llewellyn, 2003); these are evidently not unproblematic exercises. The literature has presented gaps in the conceptualising of the nursing account (Pattison, 2001; Jacobs, 2004; Tilley, 2004), concerns related to power and control arising from opening the profession to external scrutiny (Lewis and Batey, 1982), and uncertainty regarding the ethical and moral foundations of the codes (Pattison, 2001). Despite these problems the literature demonstrates a degree of interest in, and evolution of, this debate and of this being extended to the clinical governance agenda (Jacobs, 2004; Tilley, 2004; Mander, 2004). The following section looks more closely at the construction of accountability by senior managers working in the Australian public sector.

2.1.2 Structural and personal accountability

Sinclair's study, of accountability in the public sector, arose in response to the development of managerial systems, stressing the increasing use of "objective and scientific connotations of accounting methodologies" (Sinclair, 1995, p. 221) and the specification and measurement of outcomes, performance and objectives. A study of 15 Chief Executive Officers (CEO) working in the Australian public sector was used to examine the complexity of accountability in practice; with Sinclair choosing to explore the conceptualisation of accountability by managers rather than examining the use of accounting methods and technologies. The focus of the study was an examination of the linguistic and interactive creation of the meaning of accountability by actors, rather than seeking to identify "real" forms of accountability. From this perspective, the various forms of accountability are always enmeshed in differing ideologies and language and capable of representing multiple meanings. Here, accountability is defined as a relationship in which people are required to explain and take responsibility for action. However, as Sinclair notes somewhat ironically, accountability is rarely this simple as it is constantly shaped by the surrounding social norms, ideologies and language, and resides:

in a 'bottomless swamp', where the more definitive we attempt to render the concept, the more murky it becomes. Like power, accountability can be understood as something a person is or feels (a personal attribute or affect), something a person has been granted (an obligation bestowed or part of a job contract), something a person exchanges for authority (a property of a relationship), a more abstract and impersonal property of an authority structure, or an artefact of scrutiny (Sinclair, 1995, p. 221).

From these interviews Sinclair identified five forms of accountability used in the CEOs' narratives: political, managerial, public, professional and personal. These are presented through the use of two contrasting discourses which Sinclair terms structural and personal. The structural discourse presents accountability as abstract, detached and rational; an unproblematic process capable of being delivered independently of personalities and organisational politics. The personal discourse refers to confidential and anecdotal information in which accountability is presented as ambiguous and concerned with the risk of personal failure.

Sinclair presents and discusses the five constructions of accountability related to the personal and structural discourses. Of these, managerial and professional accountability are reviewed in this section. First, according to the structural discourse, managerial accountability is associated with contracts and hard outputs, whilst in the personal discourse this accountability refers to risk factors. Second, professional accountability is described as a sense of duty and membership of a privileged group which values expertise and integrity; in the structural discourse this is viewed as unproblematic and simple to assert, although the CEOs expressed concerns related to dealing with other professionals. In the personal discourse of professional accountability this was expressed in terms of fidelity to values which are perceived to be particularly powerful and binding:

such as respect for human dignity and acting in a manner that accepts responsibility for affecting the lives of others [...]. It rests on the belief that ultimately accountability is driven by adherence to internalised moral and ethical values. Because it is enforced by psychological, rather than external, controls (Sinclair, 1995, p. 230).

Importantly, Sinclair identifies the ability of managers to hold varying accountabilities simultaneously, arguing that the chameleon nature of accountability be recognised and the continual processes of reconstruction it undergoes in response to the varying ideologies and backgrounds of individuals. Overall, the research indicates the need to consider accountability as being concerned with subjective, linguistic, interactive and political processes.

The strengths of this study include the identification of accountability as “subjectively constructed” and changing with context (Sinclair, 1995, p. 219), and of the ability of managers to hold and mediate between varying accountabilities through use of structural and personal discourses. This suggests that it is not just external power and calculative methods that drive the form of accountability but also the power of recounting on the part of managers who offer:

‘competing, potentially contradictory ways of giving meaning to the world’ [...] they are, for CEOs, an essential device in the process of actively constructing and renegotiating their accountability (Sinclair, 1995, pp. 233-234).

2.2 Accountability and organisational control

The increasing reliance on the use of accountability systems across public and private sector organisations has been matched by the critique of these developments in accountability arrangements. This section considers the seminal analysis by Power (1997) of the increasing reliance on audit systems, Annandale’s (1996) study of the impact of risk management on nursing and finally, consideration of two studies examining the effect of accountability systems on staff within organisations (Roberts, 1991, 1996; Lindkvist and Llewellyn, 2003). A significant feature of these studies is the breadth of theoretical perspectives which are drawn upon.

2.2.1 Audit, accountability and risk management

Power (1997) presents an analysis of the widespread use of audit systems across all organisational settings which have resulted from changes in governance and:

attempts to re-order the collective and individual selves that make up organizational life (Power, 1997, p. 42).

Power links these changes in governance and control with the three programmes: NPM; changes in regulatory style which draw from internal and external audit systems; and finally, the development of quality management, new markets and professional opportunities in assurance services. These developments are viewed as having given rise to an increasing concern with organisational control and with making individuals and organisations accountable. The study does not examine audit methods in detail but rather is concerned with their increasing use across organisational and institutional settings. It includes a review of the introduction of medical and clinical audit, this aspect enabling consideration of the complex interaction between professional and managerial knowledge, systems and goals.

The basis of Power's approach to accountability is that the giving and monitoring of accounts related to us and to our actions, forms an integral part of acting as a rational individual and provides the fabric of normal human behaviour. Consequently accountability is viewed as having its basis in normality, with the explicit checking of accounts only occurring in those circumstances where distrust or concerns have arisen. It is this situation of normality which Power describes as having been transformed by recent societal and managerial developments and, specifically, as underpinning the development of an "[a]udit society" (Power, 1997, p. xv). Here the audit society is characterised by the increasing attention placed on an ever growing variety of audit systems and processes. Power draws the theoretical explanation of these developments from Rose and Miller's (1992) work in which a distinction is drawn between programmatic and technological elements of practice. By drawing a distinction between these two aspects, Power identifies the programmatic with the:

level at which audit practices are demanded by regulatory systems. It is the level at which a certain abstract ideal of what auditing is intended to achieve subsists in policy discourse, a vagueness which allows the idea to percolate into different policy arenas and to become attached to different policy goals (Power, 1997, p. 6).

Contrasted with the programmatic level are the technological elements. These are associated with audit programmes and characterised by the use of technologies or concrete tasks including those of sampling and analysis. Power argues that it is the

vagueness of the concept of audit at the programmatic level which explains the proliferation of audit systems throughout the public and private sectors. In this perspective the audit model, whilst characterised by the use of technical skills, is also viewed as a set of seemingly neutral and portable practices applicable across a breadth of organisational levels and settings. Audit processes are therefore used to prove the legitimacy of individual and organisational performance, as a means of problem solving and also by the government to monitor organisational performance. In consequence the use of audit approaches are evident at all organisational levels including those of individual practice, departmental systems and ultimately as forming the basis of what is described as the “control of control” (Power, 1997, p. xviii). In this last formulation, Power refers to those instances where management processes have become auditable objects and available for consideration by external organisations, an approach evident in the NHS with the creation of external agencies for quality improvement including the CSBS and CHI.

The analysis includes an examination of the development of medical and clinical audit, which are presented as an example of the gradual transformation of a voluntary process into a management priority; a process which involves the creation of the “hybrid doctor-managers” (Power, 1997, p. 107). It is argued that in those instances in health care where effectiveness is hard to describe and define, a systems based approach to auditing can be introduced. These audit processes in turn are viewed as supporting the development of “abstract managerial values at the expense of other cultures of performance evaluation” (Power, 1997, p. 13) and can therefore result in the combination of clinical and managerial knowledge. This lack of clarity concerning both the object and goal of medical audit processes allow “it to express clinical and managerial aspirations simultaneously, aspirations which are themselves blurred” (Power, 1997, p. 108). It is argued that the audit processes arising from these arrangements can be viewed as more concerned with prioritising those areas which can be audited in terms of efficiency and economy. Importantly, Power argues that this also provides a conception of performance evaluation in terms of cost effectiveness which:

overcomes the problems of an evaluation community whose epistemology is constructivist, and therefore less useful for policy purposes (Power, 1997, p. 118).

The programmatic value of audit is for Power, located in the operationalising of accountability associated with the relationship between principals and agents. Significantly, this relationship is identified as being based on a “legitimate reciprocity” (Power, 1997, p. 134) between principles and agents and without which auditing would be a one-way surveillance. Thus it is argued that:

What makes auditing auditing is the legitimate requirement for one party to give an account of those actions relevant to its relation to another party (Power, 1997, p. 134).

Despite the centrality of legitimacy to constructing and agreeing accounts, this remains a complex process due to constraints arising from institutional and organisational factors. The concept of legitimacy has been analysed comprehensively by Suchman (1995), who argues that despite the widespread use of the concept, legitimacy has received little scholarly attention resulting in fragile conceptual and theoretical moorings in both institutional and strategic literatures. Suchman explains the concept in terms of the “normative and cognitive forces that constrain, construct, and empower organizational actors” (Suchman, 1995, p. 571). Accordingly legitimacy is defined as socially constructed, with evaluative and cognitive dimensions, and based on a:

generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions (Suchman, 1995, p. 574)

Drawing from Meyer and Rowan (1977), Suchman identifies how legitimacy is actively sought by organisations, and how organisations that “lack acceptable legitimated accounts of their activities [...] are more vulnerable to claims that they are negligent, irrational or unnecessary” (Suchman, 1995, p. 575). Furthermore, Suchman identifies three types of legitimacy within organisational settings, terming these pragmatic, moral and cognitive legitimacy. The pragmatic form is concerned

with the “self-interested calculations of an organization’s most immediate audiences” (Suchman, 1995, p. 578); moral legitimacy refers to the normative evaluation of an organisation; and, finally, cognitive legitimacy is described as comprehensibility or taken-for-grantedness. Thereafter, Suchman details a range of strategies available for use by managers to gain, maintain and repair organisational legitimacy.

Power (1997), drawing from a broadly constructivist and institutional argument also considers the problematic associated with organisational legitimacy, and in particular with reference to audit processes. Thus he discusses the anomalous situation that may arise when audit results based on technically incorrect information, retain legitimacy within an organisation. This, it is argued, arises from the ability of audit processes to hold together diverse aspects of an organisation and to provide a window on organisational activities. Power reviews these circumstances with reference to Meyer and Rowan’s (1977) seminal article on the role of institutional myths in the development of formal organisational structures. Meyer and Rowan describe institutionalisation as occurring when social processes and obligations take on a rule-like structure and are accepted as facts. These rules are described as “myths” or:

manifestations of powerful institutional rules which function as highly rationalized myths that are binding on particular organizations (Meyer and Rowan, 1977, p. 343).

The “dramatic enactments” of these myths are described as pervading all aspects of modern societies (Meyer and Rowan, 1977, p. 346), providing the building blocks from which formal organisations are constructed and are subsequently accepted by social actors as facts. These myths are identified with the proliferation of formal organisations in society having provided a means whereby organisations can gain legitimacy, resources and enhanced prospects. However, despite the impetus for organisational development, problems are identified as arising from the interaction between organisational and institutional requirements. Amongst these are difficulties associated with the requirement for institutional evaluation. Thus systems of evaluation driven by external institutional requirements may potentiate problems related to the technical efficiency of organisational systems. Meyer and Rowan argue that the inappropriate use of evaluation systems and inspection “can uncover events

and deviations that undermine legitimacy” (Meyer and Rowan, 1977, p. 359). Drawing from this argument Power adds that external evaluation can act as a:

destabilizing and deligitimizing activity that organizations will wish to buffer from their core activities (Power, 1997, p. 96).

In answer to this potential problem Meyer and Rowan identify the use of “decoupling”, an organisational strategy which protects formal organisational structures from evaluation on the basis of performance. They also add that in so doing “institutionalized organizations minimize and ceremonialize inspection and evaluation’ (Meyer and Rowan, 1977, p. 359). Thus organisations are viewed as ensuring that:

inspection, evaluation, and control of activities are minimized, and coordination, interdependence, and mutual adjustments among structural units are handled informally (Meyer and Rowan, 1977, p. 357).

This enables managers and external stakeholders to assume that formal organisational structures are working, by buffering them from the identification of anomalies and inconsistencies within technical operations. Power identifies audit departments as creating buffering zones between organisational systems and institutional requirements. Accordingly, Power notes, audit programmes can be viewed as rituals of inspection, producing comfort and organisational legitimacy even though this may be more concerned with “auditable form rather than substance” (Power, 1997, p. 96). Although noting that Meyer and Rowan’s thesis can only be substantiated empirically, he also adds that a:

prima facie sign of decoupling is the creation or enhancement of organizational sub-units explicitly to manage the external audit process (audit committee, internal auditors, audit officers) (Power, 1997, p. 96).

By applying this concept of decoupling to the analysis of auditing in three organisational contexts, including health care, Power identifies a form of “inverse decoupling” as having resulted from the implementation of medical audit. Thus the

external requirement for evaluation is described as having been transformed by the medical profession into an internal process, and the processes and outcomes made invisible to external agencies, “other than by assertions that audit has taken place” (Power, 1997, p. 106). These findings are similar to those of Kerrison et al. (1993, 1994).

Finally, Power adds a cautionary note regarding the operationalisation of accountability arrangements through audit processes which may in some instances become an organisational ritual concerned with a “dramaturgical performance” (Power, 1997, p. 141). He states that the development of this upward accountability within organisations does not necessarily result in improvement or better accountability and may, in fact, result in systems which are more concerned with providing evidence on paper rather than improving communication and dialogue.

A view of organisational control and accountability, at the level of individual practice, is presented by Annandale’s (1996) depiction of the effect of the risk society on the nursing profession and the changes in accountability associated with the development of patient consumerism. In this view the boundaries of accountability and individual responsibility are shown as being in a state of continual flux. The theoretical basis for this study is drawn from Lash’s (1994) risk society and depicts nurses in the acute sector who, as a result of the publication of the Patient’s Charter (DoH, 1991), are called to account by health care consumers. This in turn led to the development of defensive regimes by the health care teams and an increasing use of various forms of vigilance, including the surveillance of other staff and a reliance on the production of documentary evidence.

Annandale argues that the emergence of this view of patients as risk generators has undermined the development of “new nursing”, an approach based on the creation of partnerships with patients. Consequently, nurses were portrayed as trying to second guess potential risks and creating systems to control them. This resulted in an increased reliance on documentary evidence and partnerships with other staff who, in their turn, were also viewed as risk generators. Thus nurses were depicted as

reflexive actors, constantly involved with processes of monitoring themselves and others. They are also described as thinking of accountability all the time and of referring to concerns about litigation and other risks, although interestingly few staff were found to have been involved in patient complaints. Whilst changes in accountability were said to be causing a high degree of stress for the staff this was perhaps more apparent than real, with nurses covering themselves through the writing of extensive accounts of the patient care provided. Annandale describes this use of documentation, whilst intended to provide increased security and protection, as a colonisation of the future. Problems were also identified as arising from the fact that, whilst accountability is identified as an aspect of the professionalising agenda of nursing, there is now a seeming:

coherence between nursing and midwifery's *own* long-standing push for autonomy and individual accountability, and the strong emphasis that management now places on *individual* responsibility (Annandale, 1996, p. 448).

It is argued, however, that the loss of line management responsibility and associated exclusion of members of the nursing profession from channels of communication, knowledge and power, may result in nurses and midwives turning to:

defensive practices that are not in the interest of good patient care in an attempt to create a tract of security and to close-off personal risk (Annandale, 1996, p. 449).

2.2.2 Individualising and socialising accountability

An influential approach to studying accountability in organisations is presented by Roberts (1991, 1996), in which accountability is considered as a set of institutionalised social practices, alongside the consequences arising from systems of accountability. These systems are described as:

a form of social relation which reflects symbolically upon the practical interdependence of action: an interdependence that always has both a moral and strategic dimension (Roberts, 1991, p. 367).

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These studies arose from Roberts' concern that the forms of accountability used by organisations, which he identified respectively as individualising and socialising forms, were causing an artificial divide between the strategic and moral concerns, pushing ethical issues to the periphery of organisations. Roberts presents a story of the twists and turns of these two forms of accountability, drawing upon theories proposed by Foucault (1977) and Habermas (1971, 1987) to explore the artificial divide between these and of the potentially destructive consequences for staff.

Of these two forms of interdependent accountability, individualising accountability is presented as the most powerful and legitimate instrument for making action visible whilst, paradoxically, remaining comparatively invisible to staff. In this form, disciplinary power is exerted through various technologies which are explained with reference to Foucault's (1977) thesis of the disciplinary society. Accordingly, discipline is enabled by the creation of accounting technologies, strategies, techniques and procedures which translate and enact aspects of government policy and also establish lines of visibility. These forms of control are described as pervasive in all aspects of life although, according to Roberts, they are notably evident in the work context associated with the use of accounting systems. Accordingly, audit approaches and accounting systems are described as gaining their power through the use of quasi-scientific or accounting techniques. These are said to imitate scientific methods by presenting findings as objective neutral facts, and to develop lines of visibility related to organisational and individual activities.

Roberts argues that the use of individualising forms of accountability constitute individuals through the use of these technologies of power, resulting in the development of people in the work environment who are self-absorbed, concentrating only on performance requirements and concerned with monitoring the demands of others. This hierarchical accountability also draws upon Foucault's (1977) depiction of disciplinary power to portray individuals within organisations as economic units, isolated from each other and working in compartmentalised organisational spaces. Individualising accountability is also said to give rise to

calculating and hierarchical relationships between individuals, based on processes of continuous comparison and competition.

Roberts also identifies a contrasting form of accountability as existing within organisations. He describes this socialising accountability with reference to Habermas' (1971) distinction between work as rational purposeful action and interaction as communicative action, governed by reciprocal expectations and consensual norms. It is proposed that socialising accountability occurs within the informal spaces in organisations, for instance coffee rooms, where individuals are able to talk to each other without being characterised by their role or function. This enables individuals to seek to make sense and agree meanings with a:

relative absence of asymmetries of power, and a context for the face-to-face negotiation of the significance of organizational events (Roberts, 1991, p. 362).

Having drawn a sharp distinction between these two forms of accountability Roberts (1996), in a continuation of his thesis, argues for a more inclusive concept of accountability which is capable of recognising that:

All accountability has the effect of acknowledging self, and focusing attention within the stream of experience. Different forms of accountability however, build very different senses of self and our relation to others (Roberts, 1991, p. 363).

Therefore a dialogical form of accountability is added to the thesis, a development explained by reference to new forms of organisational technology. These are described as including organisational learning, empowerment, culture management and as extending "technical rationality into the domain of the 'affective'" (Roberts, 1996, p. 53). In proposing the use of dialogue, Roberts' intention is to provide a means of overcoming the divide by enabling the free flow of information between staff, leveling social processes and removing those barriers created by hierarchy and power asymmetries.

Although there are evident problems with Roberts' (1991) thesis, including the restricted view of the socialising forms of accountability as only occurring in the informal spaces within organisations, this study is nevertheless interesting for the exploration of the potentially damaging effects arising from formal accountability systems. A number of critiques of this approach have been presented including that by Lindkvist and Llewellyn (2003) who, whilst recognising the importance of Roberts' study, argue that organisations do not fall neatly into the two sections represented by individualising and socialising accountability. They also suggest that, to some extent, Roberts' model serves to demonise accountability and to portray organisations as the instrumental systems that result in the suppression of moral debate. The authors also suggest that this top down model ignores the ability of people in organisational settings to act and make decisions. This has the potential to result in situations where everyone has procedural accountabilities, but no one is responsible for the wider consequences.

Lindkvist and Llewellyn (2003) propose that the imbalance in Roberts' model be addressed by use of the term responsibility, suggesting a model capable of recognising the interplay between formal and informal accountability systems and of enabling recognition of the importance of individual agency and responsibility. This approach is of particular note given the identified concern with rebalancing the accountability processes through the inclusion of responsibility, a factor evident in nursing definitions of accountability (Batey and Lewis, 1982; Melia, 1995). Lindkvist and Llewellyn argue that the inclusion of responsibility will enable recognition of the moral consequences of actions and of the effects which may occur over a longer span of time. The authors suggest that they are building on the capacity of individuals to relate consciously to situations, use discretion in decision making, consider individual and group responsibility for actions and to build consensus and trust between team members. Significantly, they oppose a Foucauldian reading of individuals in organisations as subjugated, presenting them instead as capable of acting in reflective ways and of using a range of interpretive skills with the construction of meaning through interpretation, presented as a "skilled personal accomplishment" (Lindkvist and Llewellyn, 2003, p. 257). Building upon the

Habermasian dichotomy between work and interaction, individuals are viewed as reflexive actors with both individual and communal responsibilities, and engaged in “thinking accountability” (Lindkvist and Llewellyn, 2003, p. 269). Thus the authors describe their model as building upon personal accountability by linking individual history and experience with responsibility for decision making:

In Habermas’ terms, we can speak here of the individual drawing on his entire lifeworld background. When the individual ‘decides’ to follow his or her own conscience or idiosyncratic reason—it is the lifeworld experience relating to the reproduction of culture, society and personality that provides a richly varied resource base (Lindkvist and Llewellyn, 2003, p. 269).

2.3 Accountability as narrative interaction

The importance accorded to discursive processes and social interaction has become increasingly evident in the accountability literature. This section explores three studies: firstly, reviewing Willmott’s (1996) description of the development of the accountable self; secondly a study which draws from Bruner’s narrative and logico-scientific or paradigmatic modes (Boland and Schultze, 1996); and finally, the use of narrative accounts and enacted narratives in a study of the development of new accounting rules in the public sector (Czarniawska, 1996, 1997).

2.3.1 *Developing accountability frameworks*

Willmott (1996) presents an analysis of the social and historical context of accountability and explores the development of the accountable self. Drawing from Garfinkel’s (1967) classic definition of accountability as social action in which:

Any setting organizes its activities to make its properties as an organized environment of practical activities detectable, countable, recordable, reportable, tell-a-story-about-able, analyzable – in short accountable (Garfinkel, 1967, p. 33).

Willmott describes how the world is deemed to exist only in the ways that people account for it and continue to account for it, by drawing from reports based on the common sense accounts of those concerned. Thus the world and social institutions are considered precarious unless people constantly account, and continue to account,

for them, a factor explored by Garfinkel through a series of breaching experiments. Accordingly, accountability is viewed by social theorists as being located at the centre of human interactions and the construction of social life.

Willmott provides an overview of accountability as inextricably linked with all aspects of social interaction, with individuals positioned within varying accountability frameworks by which they are constituted and upon which they are able to exert some influence. Accountability acts as a universal aspect of social relations, concerned with rendering things intelligible by the making and giving of accounts. Individuals are depicted as giving accounts to articulate who and what they are and to account for their experiences in the world. In so doing their experience is:

rendered accountable through the (shifting) meanings that such categories convey or whatever categories we strive to replace them with (Willmott, 1996, p. 24).

Individuals are also depicted as inescapably caught in a context of historically specific and potentially contradictory accountability frameworks, which are perceived to influence how they articulate who they are and to whom they are accountable. These frameworks are in turn associated with differing social contexts and systems of power, serving to influence what counts as acceptable between varying frameworks. Accounting systems are therefore said to reflect the systems and relations of power in which they are embedded.

Despite the existence of these frameworks, Willmott indicates that the possibility of accountability is itself founded on the assumption that people can act autonomously. Individuals are capable of exerting a degree of agency and control with the subject matter for which an account is being given, always open to interpretation and negotiation. Willmott further notes that formal systems of accountability within organisations are also part of the social context and can be facilitated and distorted by the surrounding moral and political relations. Thus even in those situations where the accountability systems are perceived to be tightly defined they may still be open to multiple interpretations. These factors are of interest to the study of the development of clinical governance systems within the community setting.

2.3.2 Narrative and calculative accounts

In a response to Roberts' (1991) thesis, Boland and Schultze (1996) propose a model that is intended to recover accounting systems from the isolation of bureaucratic accountability, by locating it within "the sense making narrative of social processes" (Boland and Schultze, 1996, p. 62). The authors argue that Roberts' (1991) thesis failed to recognise that narrative forms of accountability are inherent in both the formal and informal sectors of organisations. They also add that the modes of cognition, proposed by current forms of accountability, undervalue and often suppress this narrative mode by building a mechanistic and hierarchical model in which the skills and talents of individuals are homogenised, categorised and brought into hierarchical relationships based on their relative value.

To remedy this situation, Boland and Schultze propose use of Bruner's (1986, 1990) model of two distinctive modes of cognition, the paradigmatic and narrative; also termed the calculative forms and story-telling. In a lucid account of the two forms, the characteristics and processes associated with both are delineated. The paradigmatic mode is described as being based upon an organisational principle that creates an abstract problem space within which human experience is categorised, classified and other techniques of compartmentalisation are used to establish control. The individual presented in this mode is viewed as separated, segmented and concerned with comparing and contrasting performance against a norm, a description which resembles Roberts' (1991, 1996) individualising thesis. In this mode the narrator is also invisible and the veracity of accounts is based upon the accumulation of evidence.

The narrative self however is presented as an actor who is on a stage and acting out a dramatic scene in which she/he is capable of holding multiple characters and of taking various paths. In the narrative mode of accountability Boland and Schultze portray the self as a:

character that rehearses possible courses of actions and reacts to other characters in the scene. As a character moving through time and space, the self makes its identity known (Boland and Schultze, 1996, p. 68).

Thus the narrative mode uses the telling of stories to present sequences of events located around a plot which enables identification of a beginning, middle and end. The plausibility of the individual stories is associated with the believability of the characters, the dialectical integration of the parts and the overall coherence of the plot. Thus narrative cognition is a flexible process providing the opportunity for rehearsals to explain how choices were made and to relate these to events. Neither the paradigmatic nor narrative approaches are viewed as telling the truth, although narrative approaches are described as useful in considering moral choices and in developing a link between ordinary and unexpected events. Finally, the narrative mode is anchored in the surrounding culture, with the narrator's voice and role evident in constructing the story and the other characters.

The authors apply this model to staff communication and group discussion activities using an IT based software programme, in order to explore "narrative forms of accountability, visibility and the construction of the self in a concrete setting" (Boland and Schultze, 1996, p. 72). It is suggested that the use of this system provides the opportunity for staff to re-establish narrative communication in the organisational context and, therefore, provides a means of moving Roberts' conceptualisation of informal communication into a formal organisational arrangement. This paper presents a useful exposition of Bruner's modes of cognition, with the authors arguing that the approach enables identification of the use of complex modes of thought, the exploration of exceptions and anomalies and the introduction of morality into the decision making processes.

The following study considers the application of a narrative approach to the development of new systems of accountability in organisational contexts.

2.3.3 Organisational accountability and enacted narratives

Czarniawska (1996) undertook research on the changes of accountability rules resultant from management reforms in the Swedish public sector. These developments are conceived of as resulting in a change in ethos, described as a change in the code of conduct or accountability rules used in a particular organisation

(Czarniawska, 1996). The specific focus of this research project was to understand how these changes in the accountability rules were achieved, with the research drawing from a complex array of theoretical perspectives.

The study drew upon an ethnomethodological approach, which posits accountability as the main bond in human interactions and vital to understanding the social world and social action (Garfinkel, 1967). However, Czarniawska identified problems in applying this approach in situations where change was occurring, particularly in terms of explaining changes in the 'taken-for-granted' aspects of social life. According to Latour (1993, 1994), normality in the ethnomethodological view is based on a tacit acceptance of what is normal and therefore whilst ethnomethodology is capable of explaining sociality, it cannot explain society. To remedy this position Latour proposes that the existence of society can be explained through the use of technologies. Czarniawska extends this to include the systems of accounts and in particular the accounting rules developed and used within institutions.

To deal with the identified shortcomings in the approach advocated by ethnomethodology, Czarniawska also drew upon a breadth of other theoretical perspectives including those advocated by Harré and Secord (1972), Rorty (1979), MacIntyre (1988) and Davies and Harré (1991), to provide a means of explaining both the transformation from and conformance to normality:

Accounts, so understood, may simply refer to the structure of normality, or they may take the structure of normality up for scrutiny (Czarniawska, 1996, p. 309).

The research drew specifically from MacIntyre (1988), Rorty (1979) and March and Olsen (1989) to examine those exceptional circumstances when normality is called into question and new accounts are required, described as those circumstances where abnormal discourse in an organisation becomes normal and the normal discourse becomes abnormal. Thus the study examines the discursive processes used by staff to agree and justify the new accountability rules. From this it is argued that changes in the public sector did not arise directly from planned interventions, but rather occur less systematically over a period of time. Notably, Czarniawska identified the logics

underpinning the accounts used by staff to justify their actions, as taking one of two forms: either the logic of justification or of appropriateness. The logic of justification presents rational accounts, with rationality ironically described as having “premises which all can accept (without necessarily agreeing with them), steps which all can follow and conclusions which must all be universally accepted” (Czarniawska, 1996, p. 310). By contrast the logic of appropriateness is based on explanations for actions which arise from negotiation and agreement between staff and groups, at the local level of organisations. Czarniawska also relates the logic of appropriateness to Burke’s (1969) dramatisic pentad and the congruence which can arise between act, actor and scene.

Using these two logics Czarniawska explored the changes in the Swedish public sector during the 1990s, from the interest in collective issues and solidarity to the focus on individuals and concern with efficiency. The study explains the gradual development of a new system of accounting based on the actions of individuals and use of:

discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines (Davies and Harré, 1991, p. 48).

The stages in the development of new rules include the initial agreement that the old rules were obsolete, the lack of agreement as to the form the new rules should take, and the staff trying to promote their own view of what they perceived to be crucial. Czarniawska identified the discursive processes used by staff across the organisations to create new accounting rules and the stages of transformation involved in these processes. Overall, this approach provides a means of viewing the transformation of organisational systems and accounts through the narratives of the actors at the levels of both management and practice.

In this way individuals are viewed, not as social dupes, but as having a vested interest in the legitimacy of the decisions and as having the ability to influence outcomes. Czarniawska’s approach is useful on a number of counts: firstly for

providing an example of research across organisational settings, which provides a means of representing the range of respondents involved in actively creating a new set of accountability rules; and secondly, for the attention to the performative characteristic of narratives as an enacted narrative (MacIntyre, 1985; Czarniawska, 1997, 2004a).

2.4 Summary

By outlining and examining theoretical approaches to accountability this chapter sought to enhance the understanding of community nursing involvement in clinical governance and the development of corporate accountability for clinical quality. The concept of accountability was found to form a central position in the theoretical considerations of a number of disciplines including nursing, management, accountancy and organisational studies. Whilst a breadth of theoretical perspectives and material has been examined, there are evident commonalities including an interest in defining and categorising accountability and related terms (Batey and Lewis, 1982; Sinclair, 1995; Tilley and Watson, 2004), a focus on the processes associated with interpreting accountability (Czarniawska, 1996; Lindkvist and Llewellyn, 2003; Tilley, 2004), and a concern with issues of power and control (Roberts, 1991; Power, 1997; Jacobs, 2004). Finally, a concern was also noted in the narrative processes associated with the construction of accounts and accountability systems (Czarniawska, 1996, 1997; Boland and Schultze, 1996).

The chapter began by examining approaches to defining the concept of accountability, with reference to the nursing profession (Batey and Lewis, 1982), identification of those to whom nurses were accountable and the literature associated with the codes of professional conduct (NMC, 2002). The nursing literature was wide ranging indicating the level of interest and complexity of this concept. The presentations were also associated with differing clinical settings (Annandale, 1996; Tilley, 2004; Mander, 2004) and the location of the accountability debate in the professionalising agenda of the nursing profession (Annandale, 1996; Watson, 2004). The literature also indicated the evident difficulties associated with balancing the accountability due to “referent others” (Lewis and Batey, 1982, p. 10), for instance

Abbreviations

AHP	Allied Health Professions
CEO	Chief Executive Officer
CEPP	Centre for the Evaluation of Public Policy and Practice
CHI	Commission for Health Improvement
CQI	Continuous Quality Improvement
CRAG	Clinical Resource Audit Group
CSBS	Clinical Standards Board for Scotland
DHSS	Department of Health and Social Security
DoH	Department of Health
EBM	Evidence Based Medicine
EBP	Evidence Based Practice
GP	General Practitioner
LHCC	Local Health Care Cooperative
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NMC	Nursing and Midwifery Council
NPM	New Public Management
NSF	National Service Framework
PA	Practice Accreditation
PCG	Primary Care Group
PCT	Primary Care Trust
QA	Quality Assurance
QPA	Quality Practice Award
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RHA	Regional Health Authority
SHOW	Scottish Health on the Web
SIGN	Scottish Intercollegiate Guidelines Network
TQM	Total Quality Management
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

that due to the client or to management, with some analysts extending this debate to discuss problems arising from the introduction of the clinical governance agenda (Tilley, 2004). However, this literature demonstrates a lack of theoretical development although there were notable exceptions, for example Tilley (1995, 2004). The failure to examine these concepts within an organisational context, a factor identified by Jacobs (2004), resulted in evident contradictions in the account, provided by Lewis and Batey (1982), related to the exposition of nursing accountability and the power and position of other groups within health care.

A number of the studies examined the processes involved in constructing the concept of accountability. Firstly, Sinclair (1995) used an interpretive approach to consider the processes involved in defining accountability, examining the essentially contingent and constructed nature of the concept and the role of managers in actively negotiating various accounts. This also formed a feature of the analysis by Power (1997), which focused on the primacy of certain forms of accounting in society represented by the increasing use of audit systems. This study considered the increasing requirement for the giving of accounts, representing the changes in normality from the situation where accounts were only given in exceptional circumstances, to a situation where accounts are given for a range of normal and abnormal occurrences. In the study Power cogently argues that the development of audit techniques and skills are now applicable in all situations, representing a set of portable skills which can meet the requirements in all settings. Power also provides a rare account in the NHS and quality management literature of the interaction between medical audit processes and managerial systems. The effect of the change in accountability arrangements was traced by Annandale's study of the impact of risk management on the delivery of nursing practice.

Next, the writings of management control and accountability were explored, and in particular the rich vein of writings produced by analysts with an interest in the potentially damaging effects of accountability systems on individuals in organisational settings. A recurrent theme in Roberts (1991) and Lindkvist and Llewellyn (2003) was a concern with restoring the moral balance in organisations,

which was perceived to have been damaged by the development of accountancy systems and accountability arrangements. The primary focus of Roberts' thesis was on individualising and socialising forms of accountability and, whilst this work is important for the importance placed on communication and the subsequent inclusion of a dialogical approach, there are evident problems with the distinction drawn between the two forms of accountability (Lindkvist and Llewellyn, 2003). Lindkvist and Llewellyn attempted to rectify the gaps in Roberts' thesis, re-introducing the concept of responsibility as a means of widening the moral base of discussions related to accountability in organisational settings.

Finally, the review moved to consider those studies concerned with the construction of accounts in society (Willmott, 1996), Boland and Schultze who related Bruner's (1986, 1990) concepts of paradigmatic and narrative cognition to Roberts' (1991) thesis. Czarniawska (1996, 1997) provided the opportunity to consider the use of narratives across organisational settings and to consider the essentially performative nature of these developments as an enacted narrative (MacIntyre, 1985), providing the opportunity to consider the roles, positioning of others in the organisation and the means used to construct new accounts. In this view the continual reconstruction of accountability, conceived of as ethos, is presented as the new organisational normality.

This chapter has presented the undoubted role of accounts from a number of perspectives. Czarniawska (1996) demonstrated through the development of accounts, how individuals and groups can change the ethos of organisations. The nursing profession was found to use accounts to express their professional aspirations (Watson, 2004). Organisations also used accounts to change roles and to seek to control individuals within these contexts (Roberts, 1991, 1996; Power, 1997). Finally, a means of giving accounts was proposed to deal with change and contingency and to place the concern with ethics at the centre of organisations (Lindkvist and Llewellyn, 2003). The involvement of community nurses in clinical governance draws from the experience of the nursing profession in earlier quality initiatives and the interaction between the managers and community nurses, as they

develop an account of community nursing for clinical governance. This involves the development of narratives. The approaches reviewed in this chapter have indicated the changing and constructed nature of accountability within organisational settings. As such, an approach in which accountability is viewed as an enacted narrative is advocated for examining the construction of clinical governance by community nurses of all grades.

Processes of accounting and development of accounts has undoubtedly become a central issue for organisations and professions, yet there are evident issues regarding which voice and which account. This thesis now considers the epistemological and ontological issues associated with using a narrative approach to explore nursing involvement in the development of the clinical governance agenda and community nursing account.

Chapter 3

Researching clinical governance

The approach chosen for this study lies within the interpretivist and social constructionist tradition, in which human experience is viewed as subjectively constructed through processes of talking, writing and arguing (Potter, 1996). This study draws upon the concept of the enacted narrative (MacIntyre, 1985; Morgan, 1986) and Burke's (1968, 1969) dramatisic pentad. In using these approaches the intention is to explore how community nurses, who are involved in enacting clinical governance, are conceptualising the agenda and the impact that the development of these accounts is having on both the nurses involved and the wider nursing community.

Prior to describing the study design and research method, a brief overview is given of the ontology and epistemology which steer and support the research process.

3.1 Epistemological and ontological underpinning of the research

This section outlines and discusses the design of the study including the epistemological and ontological underpinning of social constructionist research, justifying the chosen methodological approach of narrative analysis, and the concept of the enacted narrative. Finally, Burke's (1968, 1969) dramatisic pentad which was used to guide and underpin the research analysis and interpretation is presented and examined.

3.1.1 *Social constructionism*

As this study is concerned with examining how nurses generate accounts within organisational settings, an approach located within the social constructionist paradigm is suitable for capturing the narrative processes used by the community nursing staff. Social constructionism lies within the interpretive tradition along with ethnography and hermeneutics, all of which are described as being concerned with the meanings and beliefs behind political and social practices (Bevir et al., 2003). The origins of social constructionism are positioned in the work of a number of theorists including Weber (1949), Schutz (1967) and, latterly, Berger and Luckmann

(1967). In their seminal text on the sociology of knowledge, Berger and Luckmann considered life as a phenomenon constructed through the processes associated with social arrangements and practices. A useful addition to this discussion has been provided by Potter's (1996) analysis of the social construction of facts whilst Lincoln and Guba (2000), in a comprehensive analysis of qualitative research methods, present this paradigm as comprising a relativist ontology, transactional epistemology and dialectical methodology.

Typically, interpretive approaches are concerned with taking seriously the meaning embodied in social actions and with exploring these through an examination of the actions and language used. The knowledge produced is provisional and contrasts with that produced by research located in the positivist tradition, which draws upon representational epistemologies. Thus, social constructionism is concerned with understanding human actions by considering knowledge as arising from the use of language, rather than language being viewed as a reflection of an external reality. Potter (1996) draws upon two metaphors namely the "mirror and the construction yard" (Potter, 1996, p. 97), to explore these contrasting perspectives. The positivist view is depicted as the mirror of reality, a description also treated by Rorty (1979), whilst the social constructionist view is presented as actively constructing knowledge through the use of language and other communicative media.

The ontology of social constructionism has inevitably attracted a degree of interest, giving rise to discussions and debates in the literature with Potter recounting the question posed by a positivist researcher as to whether or not a social constructionist researcher would jump off a high tower. Potter observes there is little value in exploring if indeed there is an external reality, proposing that discussions of the ontological basis of social constructionism be avoided, as the world is "*constituted* in one way or another as people talk it, write it and argue it" (Potter, 1996, p. 98). Potter continues by proposing that it is more fruitful to treat the use of the construction metaphor pragmatically. This is achieved by examining descriptions as constructions, identifying how they are put together, the materials used and the events produced by them.

The primary concern of those researchers using social constructionism is, therefore, identified with seeking to understand human actions, particularly those in which individuals are actively engaged in forming models and constructs in order to make sense of their experiences. This is a continuous process as new experiences require the modification or development of models to accommodate new events. Individuals are conceived of as undertaking these activities within a societal context comprising various shared understandings, practices, discourses and languages. Thus social constructionism envisages a world constantly mediated by language and one that we continually reform and modify.

The implications for the epistemic concerns of social constructionism are also associated with the “turn to language”, a development described as promoting the reconsideration of some of the tenets of Western philosophy (Edley, 2001, p. 434). In this way, language is viewed as productive, not reflective, of the world and it is therefore impossible to see the world outside of language. Following from this, knowledge is not conceived of as neutral and apolitical, or of existing outwith its embodiment in human experience (Schwandt, 2000). Lincoln and Guba (2000) describe the epistemology of social constructionism as transactional and subjectivist, based on created findings, with Schwandt (2000) adding that it is based on an interrelationist and expressionist construction of language. From this, language is to be understood as a range of activities through which we express and realise particular ways of being in the world, with language described:

neither as primarily a tool for gaining knowledge of the world as an objective process nor “as an instrument whereby we order the things in our world, but as what allows us to have the world we have. Language makes possible the disclosure of the human world” (Taylor, 1995, p. ix) (in Schwandt, 2000, p. 198).

Therefore, research utilising a social constructionist epistemology requires a means of capturing the complexity of language and narratives. It also requires consideration of the political nature of language and knowledge construction. These factors are discussed by Schwandt who states that a recognised assumption of a social constructionist approach is that knowledge is not a disinterested or apolitical process,

but permeated with embodied aspects of human experience and ideological and political values. Following from this, two interpretations of social constructionism are identified, termed the weak and strong versions. In the weak or moderate variant although the researcher may reject some definitions or justifications of knowledge or objectivity, they will “attempt to recast these notions in a different epistemological framework and thereby preserve some way of distinguishing better or worse interpretations” (Schwandt, 2000, p. 198). Contrasting with this, strong constructionism is said to view different languages as being embedded in different forms of social life and practices and it is therefore impossible to cross between these, which Schwandt depicts as a radically sceptical and even nihilist position. A moderate position is proposed by Czarniawska (1999) who considers that the task of the researcher is concerned with convincing practitioners that other constructions are possible. Thus the researcher is identified with freeing:

practitioners from the ‘iron cage’ – from the trap that the world they have constructed for themselves has become for them. By convincing them that it does not exist ‘out there’ objectively and immutably, but that it is constructed by people in a joint effort, the researcher can also persuade them that other constructions are possible. But the decision to change and the choice of alternatives are in the hands of practitioners (Czarniawska, 1999, p. 9).

A similar approach is evident in MacIntyre’s (1985, 1988) philosophical project which argues for the development of an understanding of different traditions through the use of dialectical processes or, as Schwandt states, calls for “the argumentative resolution of competing moral claims” (2000, p. 204). The resultant connection between the researcher and participants is described as based on an ethical relationship, namely the notion of “being-for the Other” (Schwandt, 2000, p. 205). Here morality rather than being identified with rule following or a view of inevitable moral progress is described as an ethical orientation, likened to a morality of caring in which:

The core of being-for is neither right nor rights, neither the happiness nor the good of those concerned. Its core is responsibility (Schwandt, 2000, p. 205).

The evident absence of ‘facts’ in social constructionist research also has implications for the researcher as this tradition is not concerned with indicating how an external reality has or may be manipulated but, as Polkinghorne succinctly states, is more about “exhibiting an explanation” (1988, p. 21). Social constructionists are concerned with presenting the stages of the research process in a considered manner, enabling others to follow the stages, choices and means used to arrive at the interpretations presented. This process requires that the findings are built upon the careful use of methods chosen to conduct and present the research (Polkinghorne, 1988; Riessman, 1993; Barry and Elmes, 1997). The choice of an empirical approach for this study was based on the requirement to capture discursive processes, in particular the stories related to the development of clinical governance and the means used to construct and modify the agenda in response to community nursing and other factors. Thus this study is concerned with focusing on methods which identify and capture the accounts of community nurses used in the organisational setting.

3.1.2 Narrative analysis and enacted narratives

The use of narrative analysis acknowledges that the construction of meaning in the social setting is a negotiated and never ending process and that language is subject to the rules of discourse. The use of a narrative approach has increased across a breadth of disciplines and settings including social sciences, the humanities, and health care (Atkinson, 1997; Bochner, 2001; Jordens and Little, 2004). The development of interest in narratives and narrative analysis has been traced to theorists including Barthes (trans. 1977), Lyotard (trans. 1984) and Bruner (1986). It forms part of the “turn to language” (Edley, 2001, p. 434), which could be described as now developing into a “literary turn” (Czarniawska, 1997, p. 7) due to the increasing reliance on means of analysis derived from literary theory. A frequently quoted statement related to these developments was provided by Barthes (trans. 1977) who identified the prevalence of narratives in the world. They were described as:

numberless. Narrative is first and foremost a prodigious variety of genres, themselves, distributed amongst different substances – as though any material were fit to receive man’s stories. Able to be carried by articulated language, spoken or written, fixed or moving images, gestures, and the ordered

mixture of all these substances; narrative is present in myth, legend, fable, tale, novella, epic, history, tragedy, drama, comedy, mime, painting [...] stained glass windows, cinema, comics, news item, conversation. Moreover, under this almost infinite diversity of forms, narrative is present in every age, in every place, in every society; it begins with the very history of mankind and there nowhere is nor has been a people without narrative (Barthes, trans. 1977, p. 79).

Liotard (trans. 1984) also considered this topic and, in particular, the increasing crisis in the use of the metanarratives or grand stories used to understand and legitimate the world that humans inhabit. Two metanarratives were identified namely, Marxism and science, with Lyotard also examining the failures of the scientific metanarrative. Pointing towards the differentiation between scientific and narrative knowledge, Lyotard discusses the anomaly in the status accorded narrative knowledge, despite being the form of knowledge identified with legitimating scientific knowledge. This compliment is not perceived to be repaid by scientific knowledge and consequently narrative knowledge is presented as receiving little attention from the academic community. This subject was examined by Bruner (1986, 1990), who distinguished between the narrative form of knowledge and that used by the scientific paradigm. Bruner argues that whilst a great deal is known about paradigmatic or the logico-scientific mode, considerably less attention has been paid to the narrative mode which he describes as dealing with the “vicissitudes of human intentions” (Bruner, 1986, p. 16). This, despite the fact that narrative knowledge is concerned with the enacting of human intentions and the resultant consequences in terms of what individuals think, feel, know or do not know.

Polkinghorne (1988) also considers this topic, proposing the use of narrative analysis by social psychologists to explore the intentionality of human actions. Thus, the centrality of narratives to human action is acknowledged through the description of narratives as:

the fundamental scheme for linking individual human actions and events into interrelated aspects of an understandable composite (Polkinghorne, 1988, p. 13).

A pivotal factor which requires consideration in any study utilising a narrative approach is that of interpretation as an integral part of the narrative process (MacIntyre, 1985; Reissman, 1993; Czarniawska, 2004a). Polkinghorne identifies the construction of narratives with those cognitive processes concerned with organising human experience into temporally meaningful episodes, and making them available for observation and consideration by others. The study of narratives is therefore concerned with making explicit the operations that produce particular meanings and of the resultant schemes by which humans give meaning to their temporality and personal actions. Narratives are identified with gaining understanding, and providing a purpose for life, as indicated by MacIntyre (1985) in the description of life as a narrative quest through which individuals search for a unity of purpose.

Polkinghorne (1988) continues by describing the processes of narrating as being concerned with constructing stories and accounts which are used to explain events, choices made and to persuade listeners as to the veracity of this version. Central to this process is the identification of a plot to underpin the narrative and through which the account is lifted above a mere sequence of events or chronicles, to provide an explanation of events and actions. In so doing, the plot provides an explanation for the causality of events. It also provides a version of events which serves both to configure past events and to anticipate future ones. However, as noted by Czarniawska (1997, 2004a), the plots within a narrative context are rarely singular with the explanations presented usually being one among the many which could be construed from events.

It is evident that the processes of narrating and plot development may be both active and performative. This factor is considered by Czarniawska (1997, 2004a) and MacIntyre (1985) in terms of enacted narratives, with Czarniawska (2004a) noting that whether or not life actually is an enacted narrative is not an ontological claim, but rather indicates that narratives can be conceived of as enabling a rich source of material providing insight to social life. Thus MacIntyre presents:

conversations in particular [...] and human actions in general as enacted narratives (MacIntyre, 1985, p. 211).

Abstract

The introduction of clinical governance requires that community nurses participate in the development of corporate accountability for clinical performance, accounting for normality as well as exceptional events in practice. The ability to deal with change has become a necessary part of the community nursing role, a factor complicated by the geographical spread and stratification of community nursing teams. If the development of clinical governance is to avoid domination by medical or managerial perspectives, each staff group is required to represent their standpoint. There is little research on the participation of community nurses in these or previous reforms, although earlier research demonstrated increasing managerial penetration of community nursing practice. Following from MacIntyre (1985), this is a study of the enacted narrative in the community context, to understand how nurses narrate and justify their involvement in these reforms and, to examine the development of a negotiated consensus by community nursing teams. A research approach within the social constructionist tradition informed by Burke's (1969) dramatist pentad was used to explore and interpret the respondents' accounts. Narratives of clinical governance were obtained from unstructured interviews with twenty staff, including district nurses and managers in two NHS Trusts.

The study findings suggest the continuing penetration of nursing practice by management systems, and associated hybridisation of nursing and management roles. Nursing governance is enacted through clinical audit and standard setting systems, building on the history of nursing involvement in these initiatives to develop a nursing consensus on the governance of nursing practice. The majority of nurses are presented as disengaged from these events, with the resultant nursing governance systems underpinned by an apparent rather than actual consensus. This evident failure to explore the concerns narrated by the wider nursing community including, ironically, some of the respondents, indicates the potentially limited nature of the corporate accountability systems being developed. The uncertainty of the community nursing knowledge base in the face of clinical governance is illustrated, with practitioners reliant on rationalities drawn from managerial and evidence based logics. It is argued that the marginalisation of the nursing perspective by nursing governance systems, may result in a failure of the profession to develop the dialectical skills and articulacy required to present the nursing perspective in this and future developments. Difficulties arising from the way in which clinical governance is being developed are identified, highlighting the problems which may impact on the clinical governance agenda and roles played by community nurses. The findings suggest the requirement of a revised approach to the management of nurses, enabling the explicit inclusion of the nursing majority in future policy implementation.

This concept provides a means not only of considering the active role of narrating but also its use in dealing with unpredictability. Morgan refers to the paradoxical role played by individuals engaged in the processes of enactment as:

the proactive role that we unconsciously play in creating our world. Although we often see ourselves as living in a reality with objective characteristics, life demands much more of us than this. It requires that we take an active role in bringing our realities into being through various interpretive schemes, even though these realities may then have a habit of imposing themselves on us as 'the way things are' (Morgan, 1986, p. 130).

Thus individuals are involved unconsciously and yet are proactively concerned with creating the way things always have been, with the enacting of narratives providing a means of dealing with the unpredictability of life and social action. Therefore unpredictable events are not viewed as inexplicable (Polkinghorne, 1988, Czarniawska, 2004a).

The term enactment focuses attention on the performative nature of narratives and the collaborative processes involved in their development and use. As such, individuals are at best only co-authors of their narratives or, as MacIntyre observes:

We enter upon a stage which we did not design and we find ourselves part of an action that was not of our making (MacIntyre, 1985, p. 213).

The concept of enactment focuses attention on the availability of resources and scripts in a setting, from which agents both unconsciously and consciously select. The specific location for the collaborative enactment of narratives in this study was provided by an organisational setting, specifically that of community nursing. Organisational contexts have been examined by a number of theorists drawing from narrative approaches and the availability of narratives within the organisational context has been noted (Polkinghorne, 1988; Czarniawska, 1997; Llewellyn, 1999, 2003), with each workplace, group and community described as having:

a contemporary and historical repertoire of stories, sometimes divided into 'internal stories' and 'external stories', sometimes spread abroad with a hope of their return in a more legitimate form (Czarniawska, 2004a, p. 45).

Thus narratives are described as existing in all social settings, or as MacIntyre states:

we all live out narratives in our lives and because we understand our own lives in terms of the narratives that we live out that the form of narrative is appropriate for understanding the actions of others. Stories are lived before they are told (MacIntyre, 1985, p. 212).

Narratives have been described as concerned with the dominant or legitimate stories in a particular place, at a given time and with the organisational narratives founded on polyphony, involving all of the voices involved in negotiating. Thus researchers have used this approach to explore the organisational setting; consider decision points; current themes in organisational thought; and the agency of individual actors (Barry and Elmes, 1997; Llewellyn, 2003). Polkinghorne suggests that the narrative approach will provide information about organisational norms and purposes, including the:

concealment of power plays, the mediation of contradictions between theory and practice and between group and individual needs, and building of bridges between the past and the present (Polkinghorne, 1988, p. 122).

Consideration of polyphony and multiple narratives raises questions as to the processes involved in agreeing narratives, including the interests of those individuals and groups in constructing these accounts. The factors involved in the production of narratives as a collaborative process were examined by Davies and Harré (1991) and MacIntyre (1988). Davies and Harré identified the concept of positioning with these processes defined as "the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines" (Davies and Harré, 1991, p. 48). According to this thesis the collaborative development of narratives is based on individuals being able to hold multiple positions and of using their knowledge of social structures and existing roles

to negotiate and develop new roles. In this view the development of narratives is a dynamic processes involving multiple actors and resulting in the production of various storylines within organisational contexts. Davies and Harré liken this to the creation of a braided storyline. The concept of positioning enables exploration of the assigning of parts to the self and others. It also permits the existence of contradictions between the roles held by individuals and illustrates the facility of individuals to be involved in the processes of narrative construction. Czarniawska (1996) indicated the usefulness of this concept in her study of the changes in accountability rules in public sector organisations, which was explained by the positioning of some actors in influential roles.

MacIntyre (1988) also indicates interest in the apparent lack of control and involvement displayed by some groups and individuals in these processes. This, it is proposed, is linked with an imbalance between the power and influence of some groups over the language and in the means of arguing. In this instance MacIntyre (1988) refers to the formal processes of conducting arguments, as a specialist form of organisational script. Thus some groups and professions are portrayed as developing control over the use and promotion of certain methods of argument and using this to exercise a kind of:

power which favours their own interests and privileges, the interests and privileges of a class which has arrogated the rhetorically effective use of argument to itself for its own purposes. [...] the techniques for deploying which furnish a key part of the professional skills of lawyers, academics, economists, and journalists who thereby dominate the dialectically unfluent and inarticulate (MacIntyre, 1988, p. 5).

The narrative approach is also considered to provide the researcher with a rich source of material for analysis and interpretation through which, it is proposed, they are able to access not only the formal organisational systems but also the emotional life of organisations (Czarniawska, 2004a). This material is available for analysis through a range of literary approaches (Polkinghorne, 1988; Bruner, 1986, 1990). Furthermore, Czarniawska (1997, 1999, 2004a) identifies structuralist, constructionist and postmodernist approaches to narrative analysis, associated with the use of literary

genre, and the use of Burke's (1968, 1969) dramatisic pentad. This latter approach was used by Czarniawska (1996, 1997) to conduct an analysis of polyphony in an organisational setting, and to present the findings as a metanarrative. The use of metanarrative is also discussed by Riessman (1993), who identifies the advantages of producing an account which is capable of transcending the individual and of being developed into a metastory. This arises from the fact that narrative production is part of an interpretive process, with the narrator having selected from various elements to construct a persuasive or explanatory narrative. These narratives do not speak directly for themselves, but rather through the narrator's interpretation of them. As such the knowledge produced is provisional and not based on certain facts, although it is based on an epistemology that provides the opportunity to compare material produced with other interpretations.

Burke's (1969) dramatisic pentad was the approach chosen to conduct the analysis. Czarniawska (2004a) classifies this approach as structural and this, it is argued, enables the researcher to deal with a range of narratives, facilitating identification and comparison of key narratives and themes. The following section provides a context for the dramatisic model by outlining the key constituents of Burke's philosophy.

3.1.3 *Burke and the dramatisic pentad*

Burke's (1969) dramatisic pentad was used by Czarniawska (1997) to "explor[e] the relationship between language and action that constitutes social life" (1997, p. 31). Burke wrote extensively on numerous topics including philosophy, literature and poetry (Burke, 1966, 1968, 1969), and there is an associated and growing body of critical analysis related to Burke's philosophical, literary and sociological project (Overington, 1977, 1977a; Simons and Melia, 1989; Gusfield, 1989, 1989a; Signorile, 1989; Wess, 1996). This study draws on Burke's theory of social action, the dramatisic pentad and theory of dialectic, as presented in the *Grammar of Motives* (1969). The primary aim of this section is the examination of the aspects of the dramatisic pentad and Burke's approach to the dialectical use of language and human motivation. According to Gusfield (1989a), in Burke's use of drama and

dialectic each represents a partial view of reality, a process described as “[w]here the ideas are in action, we have drama; where the agents are in ideation, we have dialectic” (Burke, 1969, p. 512). Therefore, to examine human actions “the analyst must consider the whole from the standpoint of each of the terms” (Gusfield, 1989a p. 43).

Burke’s ontology has been described by Simon (1989) as an “ontological loop” (1989, p. 21), located in the difference between the physical and social worlds, with the latter conceived as being constituted through the dialectical and contradictory actions of actors in social settings that are directed at meeting their interests. Specifically, the social world is described as based on social knowledge, which is incomplete and conditioned by the most powerful intellectual frameworks and language within the surrounding context. This point mirrors MacIntyre’s (1988) observation related to the power of some professional groups over the formal means of disputation. According to Burke there is a requirement for a method of analysis capable of tracing the multiplicity of interests and viewpoints in any given situation. It must also be capable of identifying and incorporating those voices not legitimated by these dominant forces. Specifically, Burke seeks to promote the use of dialectical processes to deal with the ambiguities inherent in human actions, by acknowledging that there are no right answers to situations. The use of dialectical processes is proposed as a means of dealing with uncertainties and also of creating polyphony by using dialectic as a means of melding opposites. Thus Burke seeks to develop a system which promotes the drawing together of opposing and contradictory opinions and thoughts, proposing this as a means of becoming aware of and dealing with the conflicts and contradictions within society. Burke also proposes that the examination will provide fuller explanations of social actions, although as indicated by Gusfield (1989):

We must recognize that no one solution, no one answer is final, encompassing, or ultimate (Gusfield, 1989, p. 27).

Burke views the accounts that people give for actions as being concerned with providing verbal justifications and explanations of their own behaviour or that of

others. He also observes that there are structural and cultural bases for the particular vocabularies used, with some verbal explanations providing justification for the actions of individuals, or alternatively being used to persuade others. As such Burke places the emphasis on the “methodological inquiry into cycles or clusters of terms and their functions” (Burke, 1968, p. 445), which have become the justification for action.

For Burke, language and action cannot be separated as words are not just empty folders, but are also actions which are used to move other people to respond. Therefore language is conceived as a form of social action, affecting what we experience and then do to others with our forms of communication. To explore this social action Burke proposes use of an approach he terms dramatism and the dramatisitic pentad, which it is argued will act as the “generating principle of our investigation” (Burke, 1969, p. xv). This model acknowledges that human action is inherently dramatic and seeks to provide a means of both framing and analysing social actions, by enabling exploring of “[w]hat is involved, when we say what people are doing and why they are doing it” (Burke, 1969, p. xv). Specifically dramatism is defined as:

a method of analysis and a corresponding critique of terminology designed to show that the most direct route to the study of human relations and human motives is via a methodological inquiry into cycles or clusters of terms and their functions (Burke, 1968, p. 135).

Thus use of this approach provides for the exploration of the means used by people to express their involvement in situations, including how they frame and order their experiences and in so doing make them understandable for themselves and for others. Burke (1969) sets out the pentad as both a framing device and analytical method to explore human actions and motives. The constituent parts of the pentad are: scene, which includes the background or context of events; agent, the person or groups involved in the events; the act, the systems of acts performed; agency, how these acts were performed and the instruments used; and finally purpose, what was the intended result from these acts. The components of the pentad may seem commonplace and

indeed there are evident similarities to the questions posed by journalists and writers. Walker and Monin (2001) in their analysis of a company event liken their use of the method as simplistic or, as they term it, as a “cookie cutter” (2001, p. 276). Gusfield (1989), however, indicates that the pentad provides a means of exploring the interrelationship between the constituent parts describing it as “an impressive tool for understanding how interpretative schemes work” (Gusfield, 1989a, p. 38). Amongst the strengths identified is the ability to identify areas of imbalance within the pentad, where the primary emphasis has been placed on certain aspects rather than others. In these instances the motives underpinning an action may be dominated by one aspect of the pentad rather than another. Thus the use of dramatism is said to provide a means of looking at how things are constituted and, in particular, how individuals and groups constitute experience in organisational settings.

To summarise, Burke describes language as a form of social action which is used to select, define and understand events. He defines dialectic as the means used by actors to shape situations, including their behaviours, strategies and communication. This focus on the dialectical element is also paralleled by Burke’s focus on behaviour as drama, situated in the context of conflict, resolution, transformation, and processes of change. The dramatisic pentad provides a corner stone in this thesis and is considered particularly apposite as a means of analysing the research narratives and constructions of a new normality by nursing staff in the community setting.

3.2 Research method

This section introduces the researcher, the participants involved in the study, and also provides an overview of the research setting within which the narratives were collected. Finally the process of data collection is described, whereby unstructured interviews were used as a site for narrative production.

3.2.1 Background of the researcher

The roots of this research project are located in the researcher’s own background and experience in the nursing profession, which spans involvement in clinical care, management, nursing education and in a number of change initiatives instigated by

successive government reforms. Personal involvement in the development, implementation and management of professional and managerial quality systems, gave rise to a number of concerns related to the philosophies associated with these systems and of the impact on the nurses involved. In particular, first hand experience of working with staff developing these systems within the clinical setting demonstrated the extent to which some nurses and managers were involved, often over and above the responsibilities occasioned by their nursing role. The provision of educational support for these nurses frequently took the form of ad hoc training programmes, with many staff appearing to learn the required skills and knowledge simultaneous to the implementation processes. I questioned the extent to which the nurses and managers were involved in formulating the means, as proposed by Colebatch (1998), whereby policies were transformed from the published statements into organisational actions, through interactions between various organisational participants.

3.2.2 Access and research setting

Ethical approval for the study was sought from the ethics committee in the regional health organisation, although in practice this committee indicated that formal approval was not required for a study involving staff working in the NHS. Thereafter, access was negotiated directly with the respective senior management in each of the NHS Trusts involved in the study. This required the presentation of a research proposal for consideration by the Trust research and development committees and, in the case of Trust 1, attendance at the Trust clinical governance implementation group. I also prepared written information for the respondents detailing the purpose and design of the study, although in practice only two members of staff indicated any interest in these. Once permission had been received to conduct the data collection, the initial points of entry and potential respondents were identified through discussions with the clinical governance manager for each respective Trust.

The research setting was provided by two NHS Trusts located in a single health region in Scotland, hereafter referred to as Trust 1 and Trust 2 respectively. Trust 1

was an integrated NHS Trust providing health care services across the range of acute, primary and long term services in both town and rural settings. Trust 2 was a community Trust providing a range of mental health, care of elderly and community related services in rural and city locations.

3.2.3 Background and roles of the participants

This research study accepted the influence of other staff and organisational narratives on the conceptualisation of clinical governance by the nursing staff and, indeed, a concern with eliciting accounts representing their influence in the design of clinical governance systems. A number of considerations influenced the selection of community nursing as the focus for this study. Firstly, there were the potential problems of developing organisational arrangements in the community setting, associated with the perceived autonomy of this group. Secondly, community nursing staff work across various organisational settings and contexts within which they represent the nursing voice. Finally, there was also the well documented development of a nursing skill mix in the community, (McIntosh et al., 2000; McIntosh, 2000), necessitating changes in working arrangements. Each of these factors, it was felt, would have an influence on the development of clinical governance. This presented an interesting milieu in which to consider the processes of conceptualisation and the nursing voice within these developments. An additional factor influencing the selection of this group was that they are comparatively under-represented in the research literature and, notably, in that of management oriented research.

Four roles were represented among the participants, namely district nurse, staff nurse, managers and clinical governance support nurses (hereafter referred to as support nurse). The district nurse is central to the community nursing team, a post held by those nurses who possess a specialist community nursing qualification, and with responsibility for assessing, planning and delegating patient care to other members of the nursing team (McIntosh, 2000). As a member of the community nursing team the staff nurses although registered nurses have not completed a specialist qualification in community nursing, and are therefore, considered to lack

the “full educational background normally regarded as essential for undertaking assessment of patients living at home” (McIntosh et al., 2000, p. 786). The managers who comprise the third group were, in the context of this research, registered nurses the majority of whom also possessed a specialist community nursing qualification. They were responsible for management and service development in the community setting, including responsibility for the development and delivery of clinical governance. The final role was filled by a qualified nurse who performed a range of activities which underpinned the implementation of clinical governance. These nurses provided specialist advice and assistance to the nursing staff and managers on aspects of the clinical governance agenda. This included assistance with clinical effectiveness and clinical audit projects and, the provision of staff training and development programmes. In keeping with the definitions provided by the Scottish Executive (2000) this role is referred to as support nurse.

The Scottish Executive (2000) identified four roles as involved in the clinical governance agenda, namely, overseeing, delivering, supporting and practising, as follows:

- Overseeing role - clinical governance committees
- Delivering role - management structure throughout Trust, including clinicians involved in management
- Supporting role - e.g. staff employed in activities underpinning clinical governance such as those involved in clinical effectiveness, audit, complaints handling and risk management
- Practising role - clinical and support staff. (Scottish Executive, 2000, para. 5).

The district nurses and staff nurses fell within the requirements of the practising role, whilst, the managers were involved in the delivery of clinical governance. There was, however, a degree of hybridisation between these roles, in particular, those of the district nurses and managers, with the former also involved in duties concerned with delivering the clinical governance agenda.

The respondents, reflecting the range of nursing roles, were selected on the basis of their involvement in aspects of the developing clinical governance agenda within